

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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5M 1/19

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 12 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) #5 Edward Ave.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS #5 Edward Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George Francis Adkins Jr.		4. DATE OF DEATH Dec. 5, 1965	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 18, 1924
9. AGE (in years last birthday) 41 yrs.		IF UNDER 1 YEAR: Months 10 Days 17 Hours 12 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Production Mgr.		10b. KIND OF BUSINESS OR INDUSTRY Bakery (Bakery)	
11. BIRTHPLACE (State or foreign country) Powellville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Francis Adkins		14. MOTHER'S MAIDEN NAME Laura Adkins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-28-8731	
17. INFORMANT Mrs. Amanda M. Adkins (Wife)		Address #5 Edward Ave, Salisbury, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bullet Wound of Brain Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Instant		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY CAUSE OF CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Shot self	
20c. TIME OF INJURY Month, Day, Year 5:15 p.m. 12-5-65		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Salisbury (County) Wicomico (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer		22. DATE SIGNED 12-2-65	
EXAMINER'S NAME (Type) Earl L. Royer		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) Salisbury, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 5, 1965	23c. NAME OF CEMETERY OR CREMATORY Forest Grove Cem.	23d. LOCATION (City, town or county) (State) R.D. Parsonsburg, Md.
24. FUNERAL DIRECTOR Hollaway & Co. Salisbury, Maryland.		25a. REC'D BY REGISTRAR DEC 9 1965 25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
17109									
CERTIFICATE OF DEATH									
20491									
1. PLACE OF DEATH a. COUNTY WICOMICO b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SALISBURY c. LENGTH OF STAY IN b. 28 mons d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING HILL PRIVATE SANI.					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY WICOMICO c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SALISBURY d. STREET ADDRESS SPRING HILL ROAD e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First JAMES Middle STANSBURY Last ADKINS					4. DATE OF DEATH Month DECEMBER Day 4, Year 19 65				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 29, 1882		9. AGE (In years last birthday) 83 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. FARMER			10b. KIND OF BUSINESS OR INDUSTRY TRUCK			11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DENNARD QUINTON ADKINS					14. MOTHER'S MAIDEN NAME SALLIE ANN HOLLOWAY				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) NO (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT MRS. J.C. GOSLEE Address SALISBURY, MARYLAND				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cerebral arteriosclerosis (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 1 day inter.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 6/1/58 to death , 19 58 , that (I) (we) last saw the deceased alive on 12/7 , 19 65 , and that death occurred at 1 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Ernest M. Larmore M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 12/6/65	
22c. PHYSICIAN'S NAME (Type) ERNEST M. LARMORE M.D.					22d. ADDRESS GROVE ST., DELMAR, DELAWARE				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 12/7/1965		23c. NAME OF CEMETERY OR CREMATORY PARSONS CEMETERY		23d. LOCATION (City, town or county) (State) SALISBURY, MARYLAND		
24. FUNERAL DIRECTOR'S SIGNATURE George C. Heep ADDRESS SALISBURY, MARYLAND					25a. REC'D BY REGISTRAR DEC 10 1965 DATE		25b. REGISTRAR'S SIGNATURE Charles Judge		

MEDICAL CERTIFICATION

10105

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DEPT. OF AGRICULTURE

UNITED STATES

WASHINGTON

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

January 1, 1911

TO THE HONORABLE

COMMISSIONER

OF THE GENERAL LAND OFFICE

WASHINGTON, D. C.

SIR:

I have the honor to acknowledge the receipt of your letter of the 28th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,

Yours very truly,

Very truly yours,

W. A. RORER

W. A. RORER, Secretary

General Land Office

Washington, D. C.

January 1, 1911

Enclosure

10105

RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WICOMICO MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY c. LENGTH OF STAY IN 1b 82 PENINSULA GENERAL HOSPITAL d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke - 23X-2 d. STREET ADDRESS Rt. 2 Box 299 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALBERT Middle ARCHER Last ARCHER		4. DATE OF DEATH Month DECEMBER Day 12 Year 1965	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1893 9. AGE (in years last birthday) 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Factory	11. BIRTHPLACE (County & State, or foreign country) N.C. 12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	17. INFORMANT Elsie Brittingham Pocomoke, Md. Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260x DUE TO (b) Atherosclerosis and Dehydration DUE TO (c) Renal Insufficiency Diabetes Mellitus Uncontrolled PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Unilateral Hernia, Large Prostate, Int. Hemorrhoids			INTERVAL BETWEEN ONSET AND DEATH 1 wk 1 wk
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 12/11, 1965, to 12/12, 1965, that (I) (we) last saw the deceased alive on 12/12, 1965 and that death occurred at 12:00 M. from the causes and on the date stated above.			
22a. SIGNATURE R. S. S. GARDNER, JR. 22c. PHYSICIAN'S NAME (Type)		22b. DATE SIGNED 12/13/65 22d. ADDRESS MEDICAL CENTER, SALISBURY, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-18-65	23c. NAME OF CEMETERY OR CREMATORY St. James 23d. LOCATION (City, town or county) (State) Pocomoke, Md.	
24. FUNERAL DIRECTOR Edgar Wharton		25a. REC'D BY REGISTRAR DEC 17 1965 25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 615 Hill St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Gussie M. Atkinson				4. DATE OF DEATH Dec. 18 1965			
5. SEX F.		6. COLOR OR RACE C.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 16, 1909	
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Scott Dashiell				14. MOTHER'S MAIDEN NAME Annie Wailes			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Doretta Orr 615 Hill St. Salis- Md.			
17. INFORMANT Doretta Orr 615 Hill St. Salis- Md.				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4221 Degenerative Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis (c) Interval BETWEEN ONSET AND DEATH Indefinite							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> et work Not While <input type="checkbox"/> et work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12 Nov 1965 to 18 Dec 1965 , that (I) (we) last saw the deceased alive on 18 Dec 1965 , and that death occurred at 10 PM , from the causes and on the date stated above.							
22a. SIGNATURE F. A. Turnell M.D.				22b. DATE SIGNED 21 Dec 65			
22c. PHYSICIAN'S NAME (Type) F. A. Turnell M.D. 652 W MAIN Salisbury, Md.				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/22/1965		23c. NAME OF CEMETERY OR CREMATORY Green Acres		23d. LOCATION (City, town or county) (State) Salisbury	
24 FUNERAL DIRECTOR'S SIGNATURE Clinton E. Stewart				25a. REC'D BY REGISTRAR DEC 27 1965 25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
17112
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12336 Catherine St</u> d. STREET ADDRESS <u>Salisbury Md</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Dulany</u> Middle <u>Norman</u> Last <u>Ayers</u>		4. DATE OF DEATH Month <u>December</u> Day <u>9</u> Year <u>1965</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-2-1900</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Accomac Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jerry Ayers</u>		14. MOTHER'S MAIDEN NAME <u>Maggie Jacobs</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-10 9449</u>	
17. INFORMANT <u>Cora Ayers</u>		Address <u>336 Catherine St. Salis.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4221 Degenerative Heart Disease</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>Indefinite</u> <u>Indefinite</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1 Nov</u> , 19 <u>65</u> , to <u>9 Dec</u> , 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>9 Dec</u> , 19 <u>65</u> , and that death occurred at <u>4:30</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>E.A. FURNELL</u>		22b. DATE SIGNED <u>13 Dec 65</u>	
22c. PHYSICIAN'S NAME (Type) <u>E.A. FURNELL</u>		22d. ADDRESS <u>652 W Main Salisbury Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>12-13-65</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Green Acres</u>		23d. LOCATION (City, town or county) (State) <u>Salisbury, Md</u>	
24. FUNERAL DIRECTOR <u>Lorella B. Jolley - Jersey Rd</u>		ADDRESS <u>Salis. Md</u>	
25a. REC'D BY REGISTRAR <u>DEC 20 1965</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

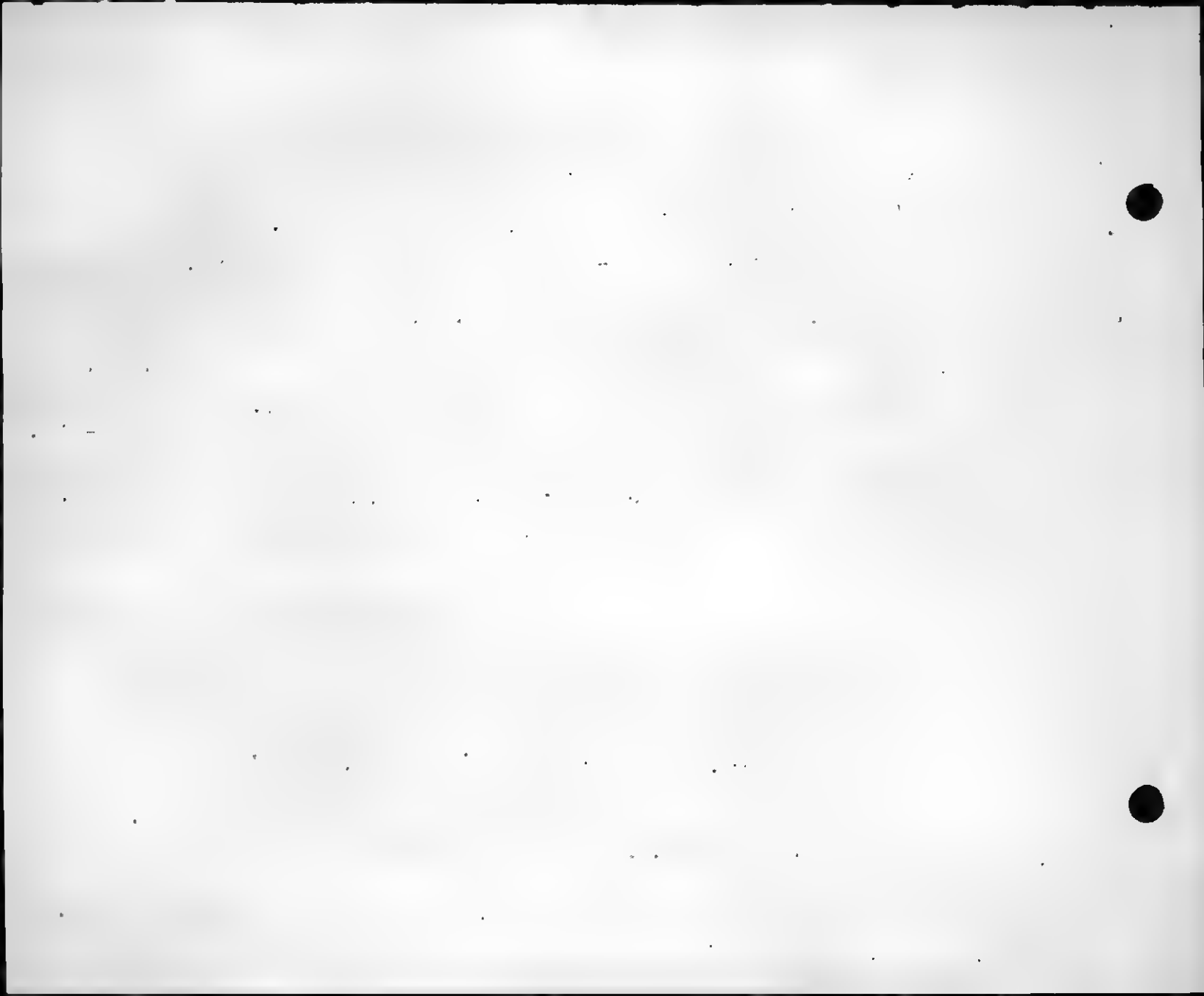
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
17113
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland c. LENGTH OF STAY IN 1b 25 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland f. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 418 Patrick Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lena		4. DATE OF DEATH Month Dec. Day 12 Year 19 65	
5. SEX Female		6. COLOR OR RACE C.	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 12, 1910	
9. AGE (in years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months 5 Days 12 Hours 19 Min. 65	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Chandler		14. MOTHER'S MAIDEN NAME Roase Washington	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Odessa MCNealey No 6 Nokmonis	
17. INFORMANT Salis- Md.		Address Salis- Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recurrent cerebrovascular accident 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive arteriosclerotic cardiovascular disease ? (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 days		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 18, 1965 to Dec. 12, 1965 , that (I) (we) last saw the deceased alive on Dec. 12, 19 65 , and that death occurred at 12:50 AM , from the causes and on the date stated above.			
22a. SIGNATURE V. Juerman		22b. DATE SIGNED Dec. 12, 1965	
22c. PHYSICIAN'S NAME (Type) V. Juerman, M.D.		22d. ADDRESS Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/4/1965	
23c. NAME OF CEMETERY OR CREMATORY Green Acres		23d. LOCATION (City, town or county) (State) Salisbury Md.	
24. FUNERAL DIRECTOR Charles E. Stewart		25a. REC'D BY REGISTRAR DEC 17 1965	
25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and on any event, within 72 hours after death.

VR A15 (4)
15M 4-64

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
18116
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 8 1/2 hours			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital				d. STREET ADDRESS Salem			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First John Middle Wesley Last Boardley		4. DATE OF DEATH Month Dec. Day 6 Year 19 65					
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1882	9. AGE (In years last birthday) 83 yrs.	10. FUNDER 1 YEAR Months 8 Days 1 Hours 1 Min.	11. UNDER 24 HRS. Months 8 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (County & State, or foreign country) Dorchester		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME unk.				14. MOTHER'S MAIDEN NAME unk.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 7		17. INFORMANT Norman Chase		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease, decompensated Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 42d1 (c) due to						INTERVAL BETWEEN ONSET AND DEATH Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 6 , 1965, to Dec. 6 , 1965, that (I) (we) last saw the deceased alive on Dec. 6 , 1965, and that death occurred at 7:05 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Juerman				22b. DATE SIGNED 12/7/65			
22c. PHYSICIAN'S NAME (Type) V. Juerman, M. D.				22d. ADDRESS Deer's Head Hospital; Salisbury, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-4-65		23c. NAME OF CEMETERY OR CREMATORY Salem Cem		23d. LOCATION (City, town or county) (State) Salem Dorchester	
24. FUNERAL DIRECTOR Brookmister				25a. REC'D BY REGISTRAR DEC 9 1965		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

الحمد لله الذي جعل
العلم نوراً والهدى
سبيلاً والنجاة
مخرجاً

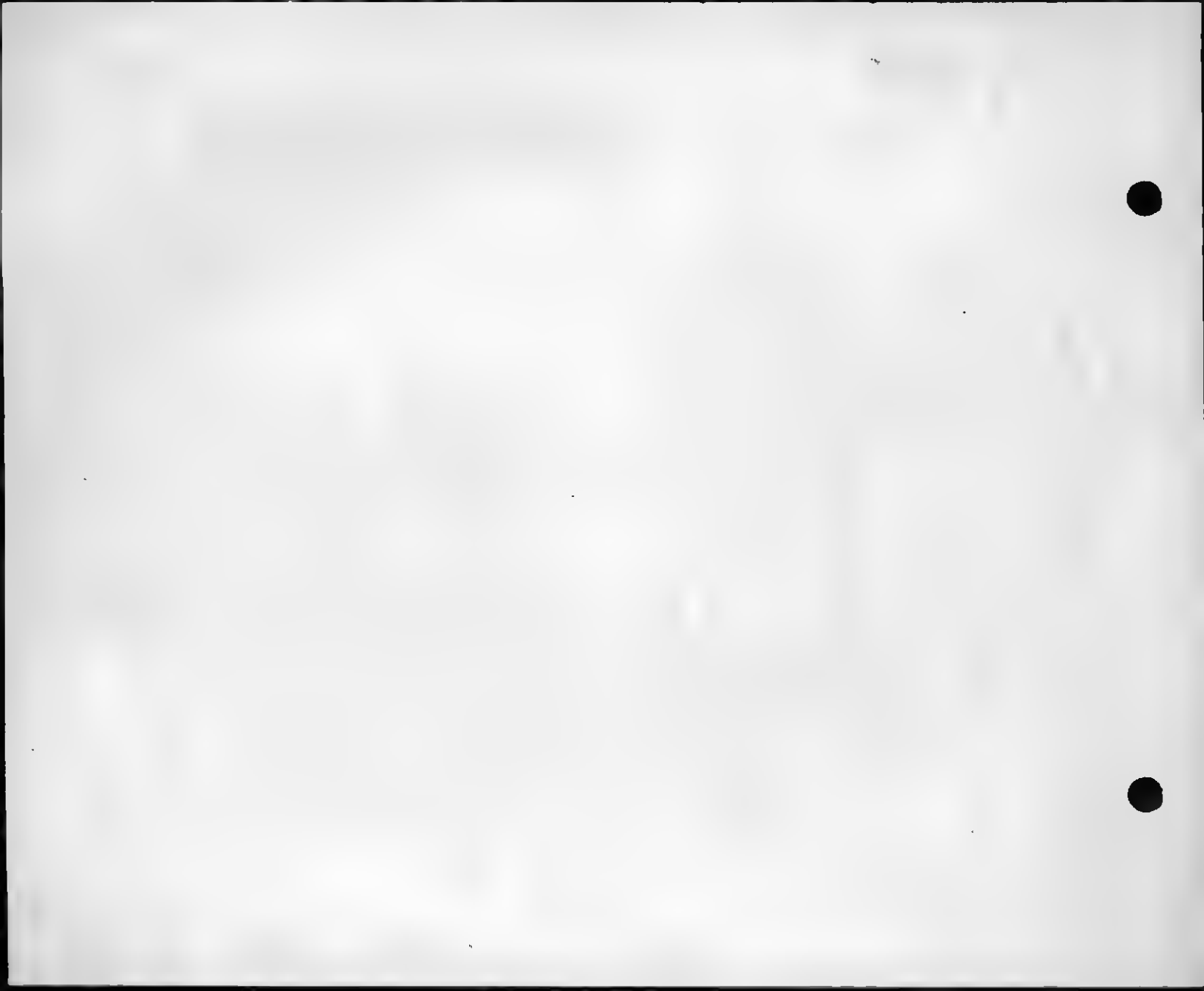
الحمد لله الذي جعل
العلم نوراً والهدى
سبيلاً والنجاة
مخرجاً

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

B7C

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>23x.2</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u> d. STREET ADDRESS <u>Pitts St</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>FLORENCE</u> Middle <u>L.</u> Last <u>Kewen</u>				4. DATE OF DEATH Month <u>December</u> Day <u>7</u> Year <u>1965</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAR. 6, 1884</u>		9. AGE (in years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>POWELLVILLE MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>WALTER ARVEY</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>MRS. JUNE McALLISTER BEAUM</u> Address <u>MD</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>501X</u> <u>Respiratory insufficiency</u> DUE TO <u>Tracheobronchitis & Atelectasis</u> (b) <u>OUE TO</u> <u>Renal secretion</u> (c) <u>Cerebrovascular accident</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>11/14</u> , 19 <u>65</u> to <u>12/7</u> , 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>12/7</u> , 19 <u>65</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Richard E. Hughes</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/8/65</u>			
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12/9/65</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BATES</u>		23d. LOCATION (City, town or county) (State) <u>SNOW HILL MD</u>					
24. FUNERAL DIRECTOR <u>Anna R Burbage Berlin Md</u>						25a. REC'D BY REGISTRAR <u>DEC 13 1965</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



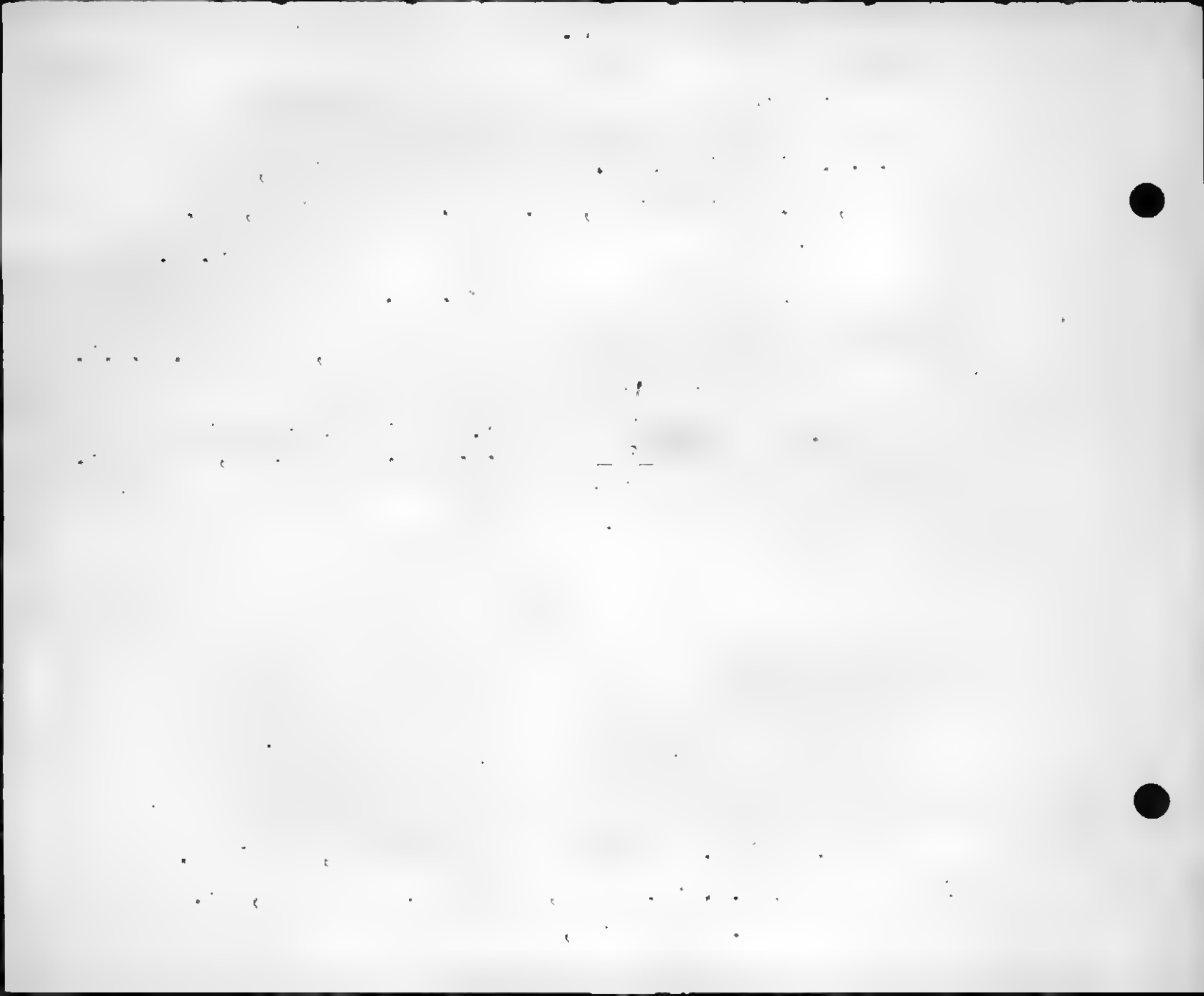
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
17116
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.D. 2, Pittsville, Md.		c. LENGTH OF STAY IN ID MARYLAND	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) At Home, Rd. 2 Pittsville, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Pittsville,	
3. NAME OF DECEASED (Type or print) Lester First Bradford Middle Bradford Last		4. DATE OF DEATH Dec. 6. Month 19 65 Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 28. 1906
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Builder	
11. BIRTHPLACE (County & State, or foreign country) Seaford, Delaware.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Levi Bradford		14. MOTHER'S MAIDEN NAME No Record	
15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, give war or dates of service) Yes War. 2		16. SOCIAL SECURITY NO. 220 09 1382	
17. INFORMANT Mrs. Bessie Bradford (Wife)		Address R.D. # 2, Pittsville, Maryland.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 4201 (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 7 hrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10/11 , 19 65 , to 12/4 , 19 65 , that (I) (we) last saw the deceased alive on 12/4 , 19 65 , and that death occurred at 11 A.M., from the causes and on the date stated above.			
22a. SIGNATURE Dr. Earl M. Beardsley		22b. DATE SIGNED 12/7/65	
22c. PHYSICIAN'S NAME (Type) Dr. Earl M. Beardsley		22d. ADDRESS Salisbury, Maryland.	
23a. BURIAL, CREMATION, 23b. DATE THEREOF Removal (Specify) Burial Dec. 8. 65.	23c. NAME OF CEMETERY OR CREMATORY Wango, Cemetery.		23d. LOCATION (City, town or county) (State) Wango, Md.
24. FUNERAL DIRECTOR Holloway & co. Salisbury, Maryland		25a. REC'D BY REGISTRAR DEC 9 1965	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11111

20190

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>Berlin Rt #3</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Joseph A. B. Briddell</u>		4. DATE OF DEATH <u>December 12 1965</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-8-1889</u>		9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Oays Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Worcester-Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elisha Briddell</u>				14. MOTHER'S MAIDEN NAME <u>Laura Brevard</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Cordella Briddell - Berlin Md. Rt #3</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 3524 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>" Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH <u>21 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 21, 1965</u> to <u>Dec 12, 1965</u> , that (I) (we) last saw the deceased alive on <u>Dec 12, 1965</u> , and that death occurred at <u>10</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>David J. Silmore</u>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)	
22d. ADDRESS				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>12-16-65</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Bethel</u>		23d. LOCATION (City, town or county) (State) <u>Berlin, Md.</u>	
24. FUNERAL DIRECTOR <u>Garrett & Jolley - Salisbury</u>		ADDRESS		25a. REC'D BY REGISTRAR <u>DEC 17 1965</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. [unclear]</u>	

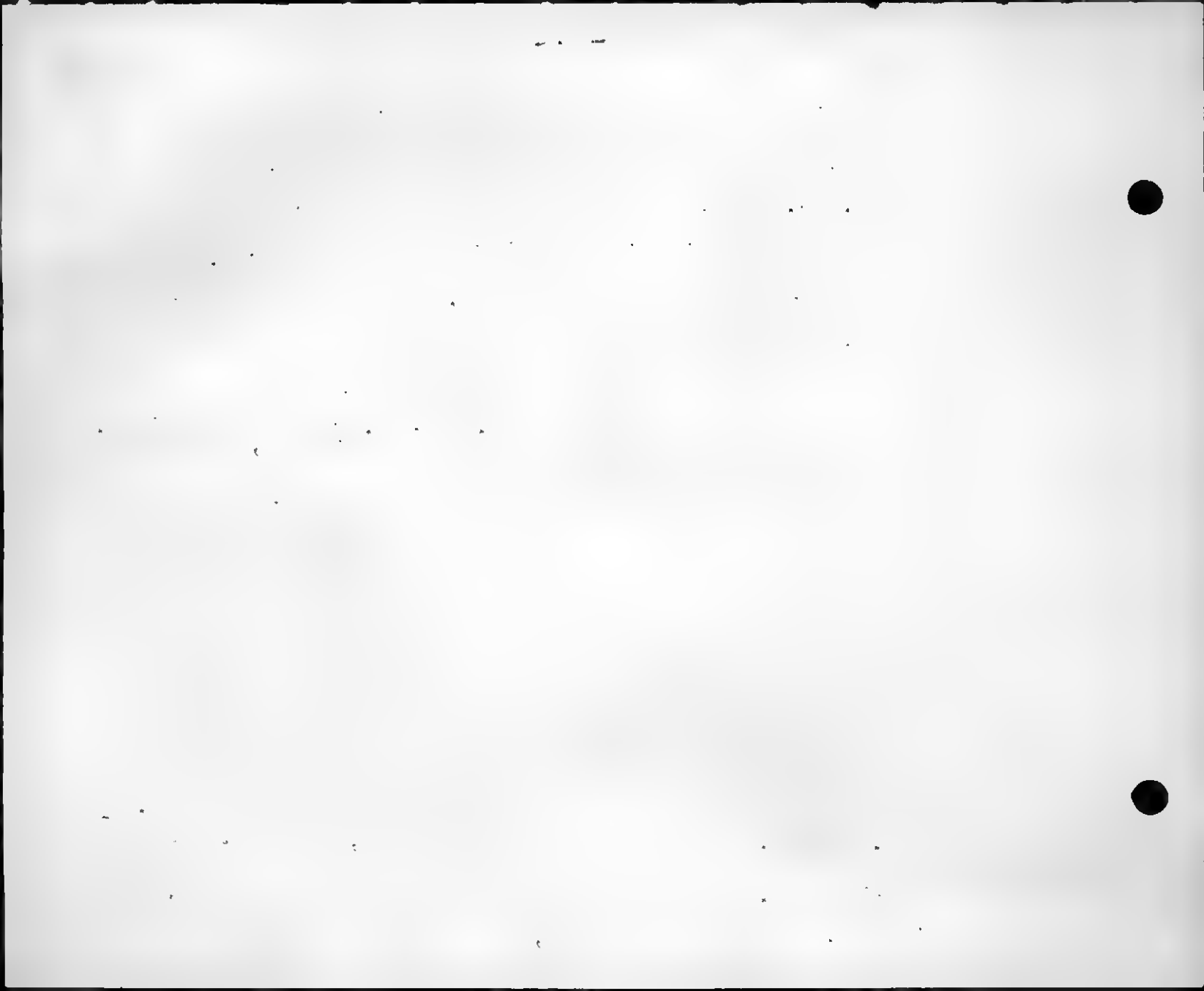


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

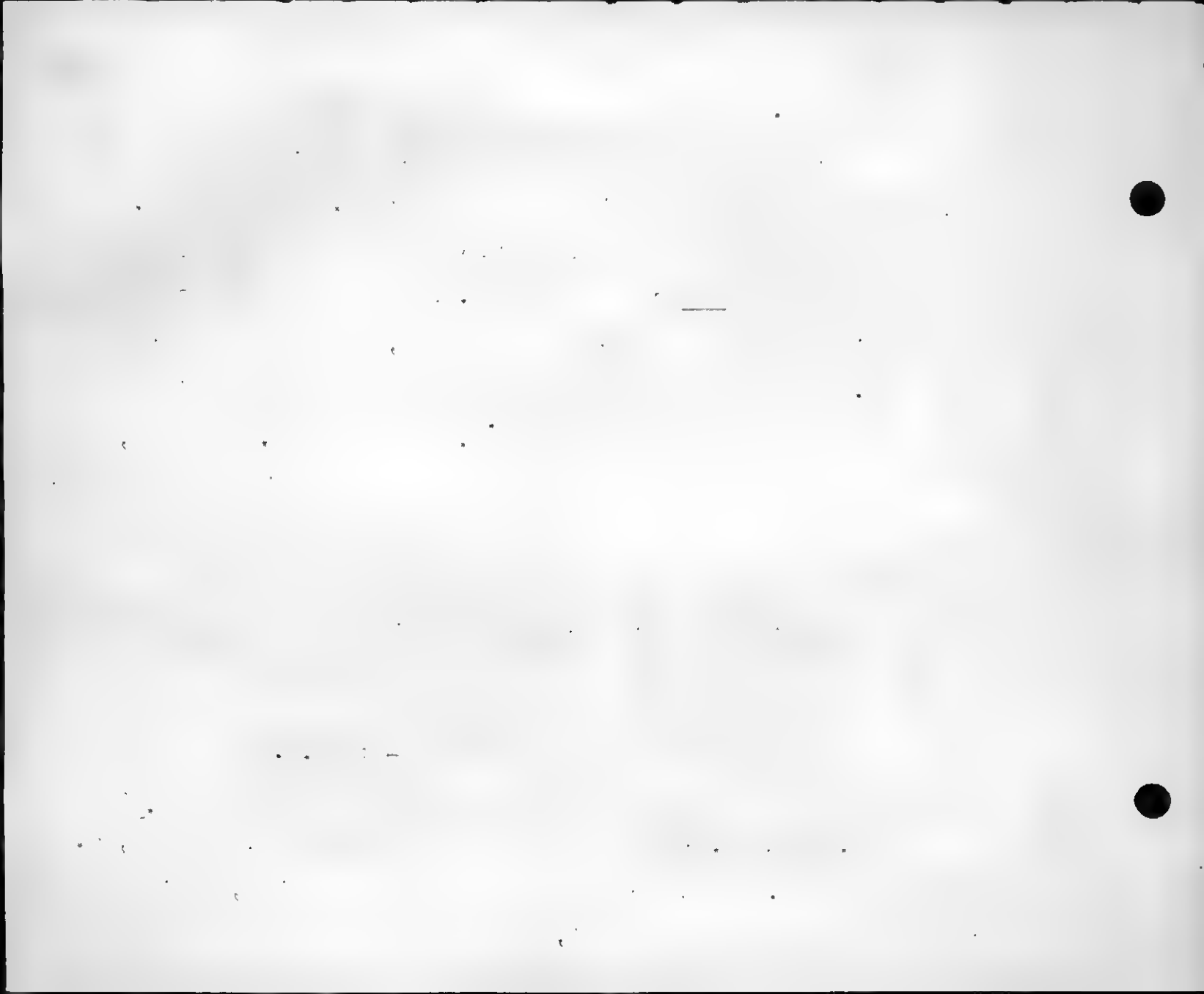
<p>1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 12 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Pen. Gen. Hospital</p>		<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 1113 Mt Hermon Rd e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>3. NAME OF DECEASED (Type or print) First LEWIS Middle WALTER (WALKER) Last BROWN</p>		<p>4. DATE OF DEATH Month DEC. Day 8th Year 1965</p>	
<p>5. SEX Male</p>	<p>6. COLOR OR RACE White</p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH Nov. 2/ 1909</p>
<p>9. AGE (In years last birthday) 56 yrs.</p>		<p>10. IF UNDER 1 YEAR Months 1 Days 6 Hours 0 Min.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner (Retired) Cpal Miner</p>		<p>10b. KIND OF BUSINESS OR INDUSTRY West Virginia</p>	
<p>11. BIRTHPLACE (County & State, or foreign country) West Virginia</p>		<p>12. CITIZEN OF WHAT COUNTRY? U S A</p>	
<p>13. FATHER'S NAME Henry Brown</p>		<p>14. MOTHER'S MAIDEN NAME Maude Richardson</p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)</p>		<p>16. SOCIAL SECURITY NO. 235-07-2771</p>	
<p>17. INFORMANT Mrs. Maude M. Brown (Wife) Address 1113 Mt. Hermon Road Salisbury, Maryland</p>		<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) right side heart failure secondary to 5-2-2-2 DUE TO (b) advanced silicosis and bronchiectasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) coal miner from West Virginia</p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>		<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A</p>	
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19</p>		<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not-While at work <input type="checkbox"/></p>	
<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>	
<p>21. I certify that (I) (this hospital) attended the deceased from 12-7, 1965, to 12-8, 1965, that (I) (we) last saw the deceased alive on 12-7, 1965, and that death occurred at 9:1 M, from the causes and on the date stated above.</p>			
<p>22a. SIGNATURE Frank R. Lewis</p>		<p>22b. DATE SIGNED Dec. 9 / 1965</p>	
<p>22c. PHYSICIAN'S NAME (Type) Dr. Frank R. Lewis</p>		<p>22d. ADDRESS Willards, Maryland</p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) Burial</p>		<p>23b. DATE THEREOF Dec. 11/1965</p>	
<p>23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park</p>		<p>23d. LOCATION (City, town or county) (State) Salisbury, Maryland</p>	
<p>24. FUNERAL DIRECTOR HOLLOWAY & COMPANY</p>		<p>25a. REC'D BY REGISTRAR DEC 13 1965</p>	
<p>25b. REGISTRAR'S SIGNATURE Charles Judge</p>		<p>25c. ADDRESS SALISBURY, MARYLAND</p>	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
17119
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 1 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springhill Private Sanitarium				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 513 N. Pinehurst Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ETHEL Middle ALICE Last CHEATHAM				4. DATE OF DEATH Month DECEMBER Day 3 Year 1965			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 1/1878	
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR: Months 11 Days 2 Hours Min. 		11. BIRTHPLACE (County & State, or foreign country) Quincy, Florida		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James G. Gibbes				14. MOTHER'S MAIDEN NAME Rhoda Elizabeth Waller			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Frank Holloway Address 513 N. Pinehurst Ave. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arterio-sclerotic Heart Disease 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral arterio-sclerosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) N/A					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1960 to 12-3, 1965 that (II) (we) last saw the deceased alive on 12-3 19 and that death occurred at 5:15 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Wilbur R. Ellis, Jr.				22b. DATE SIGNED Dec. 3/1965		22c. PHYSICIAN'S NAME (Type) Dr. Wilbur R. Ellis	
22d. ADDRESS Medical Center Salisbury, Md.		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 6/1965		23c. NAME OF CEMETERY OR CREMATORY Maplewood Cemetery		23d. LOCATION (City, town or county) (State) Durham, North Carolina	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY ADDRESS SALISBURY, MARYLAND				25a. REC'D BY REGISTRAR DEC 6 1965		25b. REGISTRAR'S SIGNATURE Charles Judge	



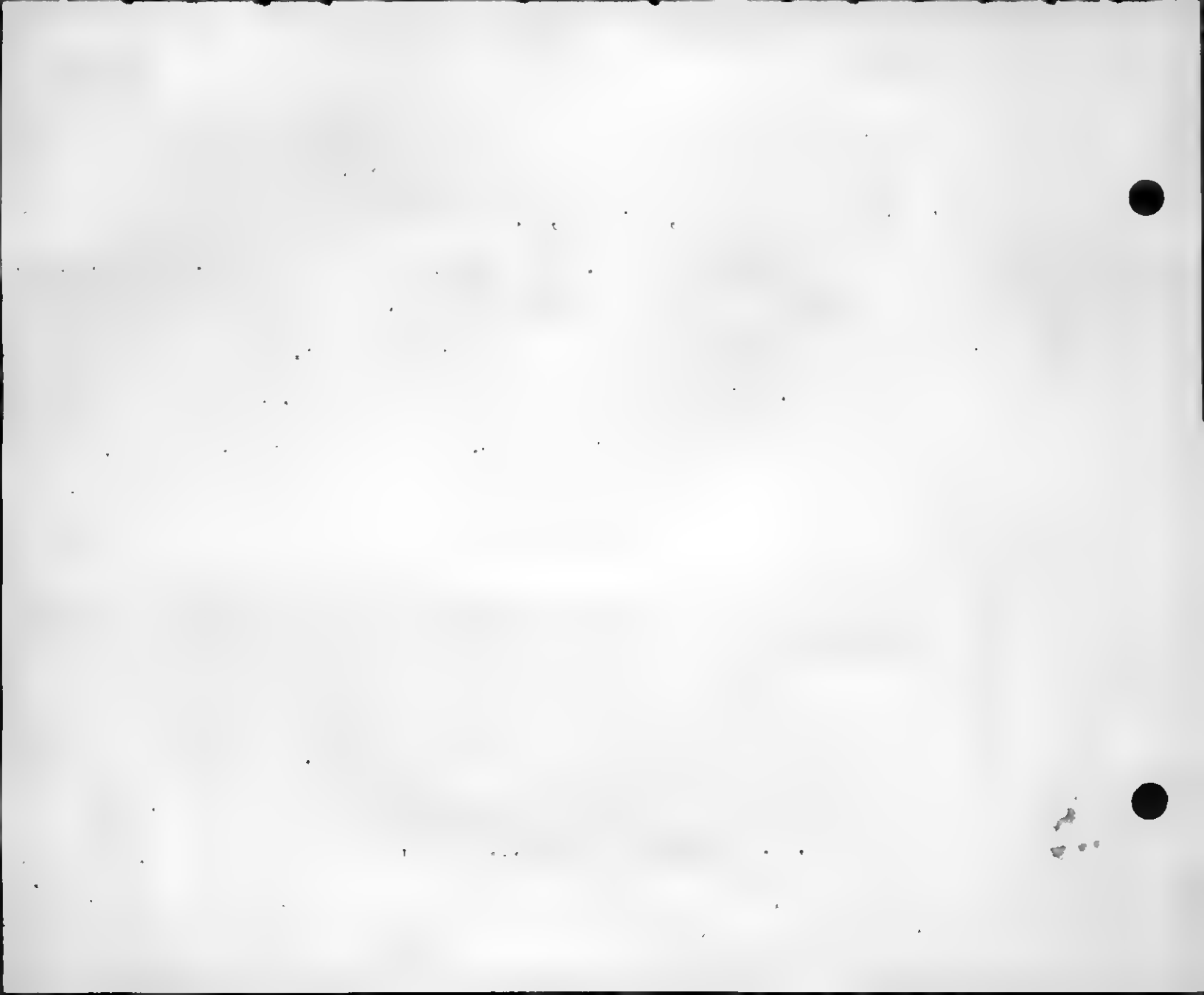
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

17120

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 269 1/2 Days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Deer's Head State Hospital, Salisbury, Md.		d. STREET ADDRESS Hurlock	
3. NAME OF DECEASED (Type or print) First George Middle Albert Last Coleman		4. DATE OF DEATH Month Dec. Day 26 Year 19 65	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 12, 1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Owner of Shoe Repair Shop		10b. KIND OF BUSINESS OR INDUSTRY Dorchester Co., Maryland	
11. BIRTHPLACE (County & State, or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas M. Coleman		14. MOTHER'S MAIDEN NAME Sarah F. Cephas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 214-34-6159	
17. INFORMANT Mrs. Ruby Elbert, Federalsburg, Md., RFD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) Arteriosclerosis DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8/11 , 19 58 , to 12/26/65 , 19 65 , that (I) (we) last saw the deceased alive on 12/26 , 19 65 , and that death occurred at 3:20 A.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED 12/27/65	
22c. PHYSICIAN'S NAME (Type) C. F. Gutierrez-Garrido, M.D.		22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 30, 1965	23c. NAME OF CEMETERY OR CREMATORY Petersburg Cemetery	23d. LOCATION (City, town or county) Near Hurlock, Maryland
24. FUNERAL DIRECTOR Leone Hampton and Son, Federalsburg, Maryland		25a. REC'D BY REGISTRAR JAN 3 1966	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
17121 CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frankford</u> d. STREET ADDRESS <u>Rural</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Eli</u> First <u>Collins</u> Middle Last			4. DATE OF DEATH <u>December 16</u> Month <u>16</u> Day <u>1965</u> Year			5. SEX <u>male</u>			6. COLOR OR RACE <u>WHITE</u>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>1-22-1894</u>			9. AGE (in years last birthday) <u>71</u> yrs.			IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>			11. BIRTHPLACE (County & State, or foreign country) <u>DELAWARE</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>Levin Collins</u>						14. MOTHER'S MAIDEN NAME <u>Mary Sheppard</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			16. SOCIAL SECURITY NO. <u>221-10-1447</u>			17. INFORMANT Address <u>Agnes Collins, Frankford, Del.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of stomach & metastatic</u> 163X DUE TO (b) <u>and pericardial effusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>12-15, 1965</u> , to <u>12-16, 1965</u> , that (I) (we) last saw the deceased alive on <u>12-16, 1965</u> , and that death occurred at <u>6:30</u> M, from the causes and on the date stated above.													
22a. SIGNATURE <u>James L. Giffner</u>						22b. DATE SIGNED <u>12-16-65</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
22c. PHYSICIAN'S NAME (Type) <u>James L. Giffner</u>						22d. ADDRESS <u>Medical Center Salisbury Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>12-20-65</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Roxana Methodist</u>			23d. LOCATION (City, town or county) (State) <u>Roxana Delaware</u>				
24. FUNERAL DIRECTOR ADDRESS <u>Douglas Nelson Frankford, Delaware</u>						25a. REC'D BY REGISTRAR <u>DEC 27 1965</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				



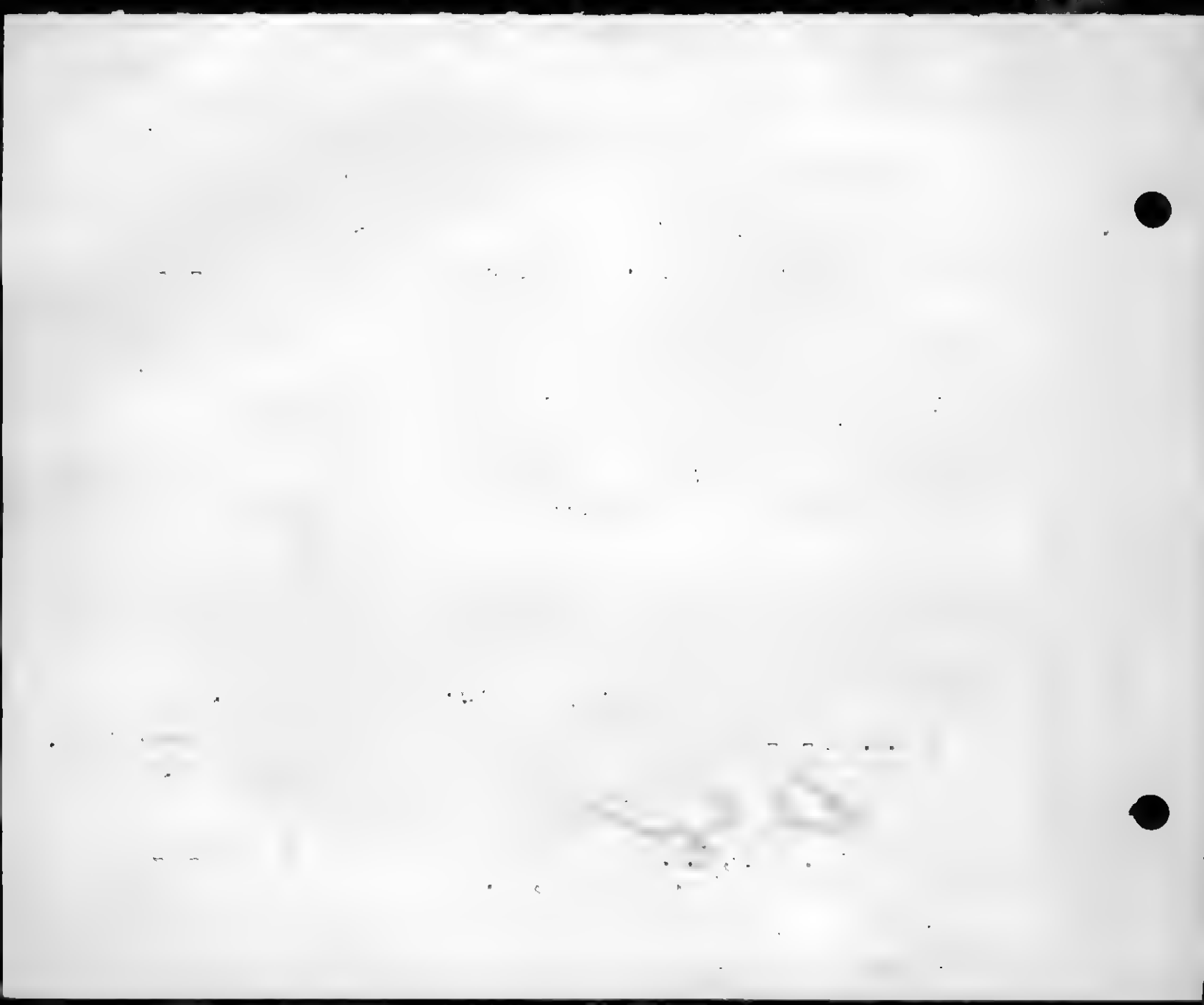
1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westover</u> d. STREET ADDRESS <u>Box 293</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sarah Ellen Collins</u>		4. DATE OF DEATH Month Day Year <u>12-22-65</u> <u>19</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/25/1912</u>
9. AGE (In years last birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <u>12-22-65</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Kings Creek Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Coston</u>		14. MOTHER'S MAIDEN NAME <u>Mary Tilghman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Harriet Martin Westover Md.</u>	
17. INFORMANT <u>Harriet Martin Westover Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Third degree burns of 90% body surface</u> 7160 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.) <u>Dress caught on fire from stove at home.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>10 AM</u> <u>12-21-65</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Own home</u>		20f. (City or town) (County) (State) <u>Westover Somerset Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer, M.D.</u>		22. DATE SIGNED <u>12-23-65</u>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		Address (Street, city, town, or county) <u>409 Camden Ave. Salisbury, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>12/26/65</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST JAMES</u>	23d. LOCATION (City, town or county) (State) <u>Westover Md.</u>
24. FUNERAL DIRECTOR <u>Anthony E. Ward Funeral Home - Crisfield</u>		25a. REC'D BY REGISTRAR <u>DEC 28 1965</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <u>James Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> d. STREET ADDRESS <u>318 CHERRY WAY.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Cooper</u> Middle <u>Cooper</u> Last <u>Cooper</u>				4. DATE OF DEATH Month <u>December</u> Day <u>9</u> Year <u>1965</u>				5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>December 9, 1965</u> 9. AGE (In years last birthday) yrs. <u>3</u> IF UNDER 1 YEAR Months <u>3</u> Days <u>15</u> IF UNDER 24 HRS. Hours <u>15</u> Min. <u>15</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Wicomico County MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>ROLAND WILLIAM COOPER</u> 14. MOTHER'S MAIDEN NAME <u>HILDA MAE DONAHAY</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>-</u> 17. INFORMANT <u>ROLAND WILLIAM COOPER</u> Address <u>-</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity (wt 5 oz)</u> 776x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u> INTERVAL BETWEEN ONSET AND DEATH <u>-</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u> 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u> 20f. (City or town) (County) (State) <u>-</u>											
21. I certify that (I) (this hospital) attended the deceased from <u>12-9-</u>, 19<u>65</u>, to <u>12-9</u>, 19<u>65</u>, that (I) (we) last saw the deceased alive on <u>12-9</u>, 19<u>65</u>, and that death occurred at <u>5:50</u> A.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>Dr. A. C. Mitchell</u> 22c. PHYSICIAN'S NAME (Type) <u>Dr. A. C. Mitchell</u> 22b. DATE SIGNED <u>12/9/65</u> 22d. ADDRESS <u>Maryland Ave. Salisbury, Maryland</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Dec. 11/1965</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Salisbury, Maryland</u>											
24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY</u> ADDRESS <u>SALISBURY, MARYLAND</u> 25a. REC'D BY REGISTRAR <u>DEC 13 1965</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>											



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. If necessary, the medical director, writing the word "pending" in pencil in item 18, may extend the time. Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 201 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17124

1. PLACE OF DEATH
a. COUNTY Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN 1b 23 4 2
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)
a. STATE Md. b. COUNTY Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City
d. STREET ADDRESS 415 Oxford St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF Isiah First Coston Middle Last
(Type or print)

4. DATE OF DEATH Dec. 28 1965
Month Day Year

5. SEX Male 6. COLOR OR RACE Negro 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH Sept. 17, 1885 80
WIDOWED ☐ DIVORCED ☐ yrs. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 10b. KIND OF BUSINESS OR INDUSTRY Yardman 11. BIRTHPLACE (State or foreign country) Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Epherim Coston 14. MOTHER'S MAIDEN NAME Mary Ginn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? No 16. SOCIAL SECURITY NO. 220-09-1991A 17. INFORMANT Drucilla Coston Address Pocomoke City, Md.
(Yes, no, or unknown) (If yes, give war or dates of service)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Shock
7124 DUE TO Multiple Corp. part. lacerations - femur + femurs
Conditions, if any, which gave rise to immediate cause (b) 7124
(a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Lacerations - femur 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

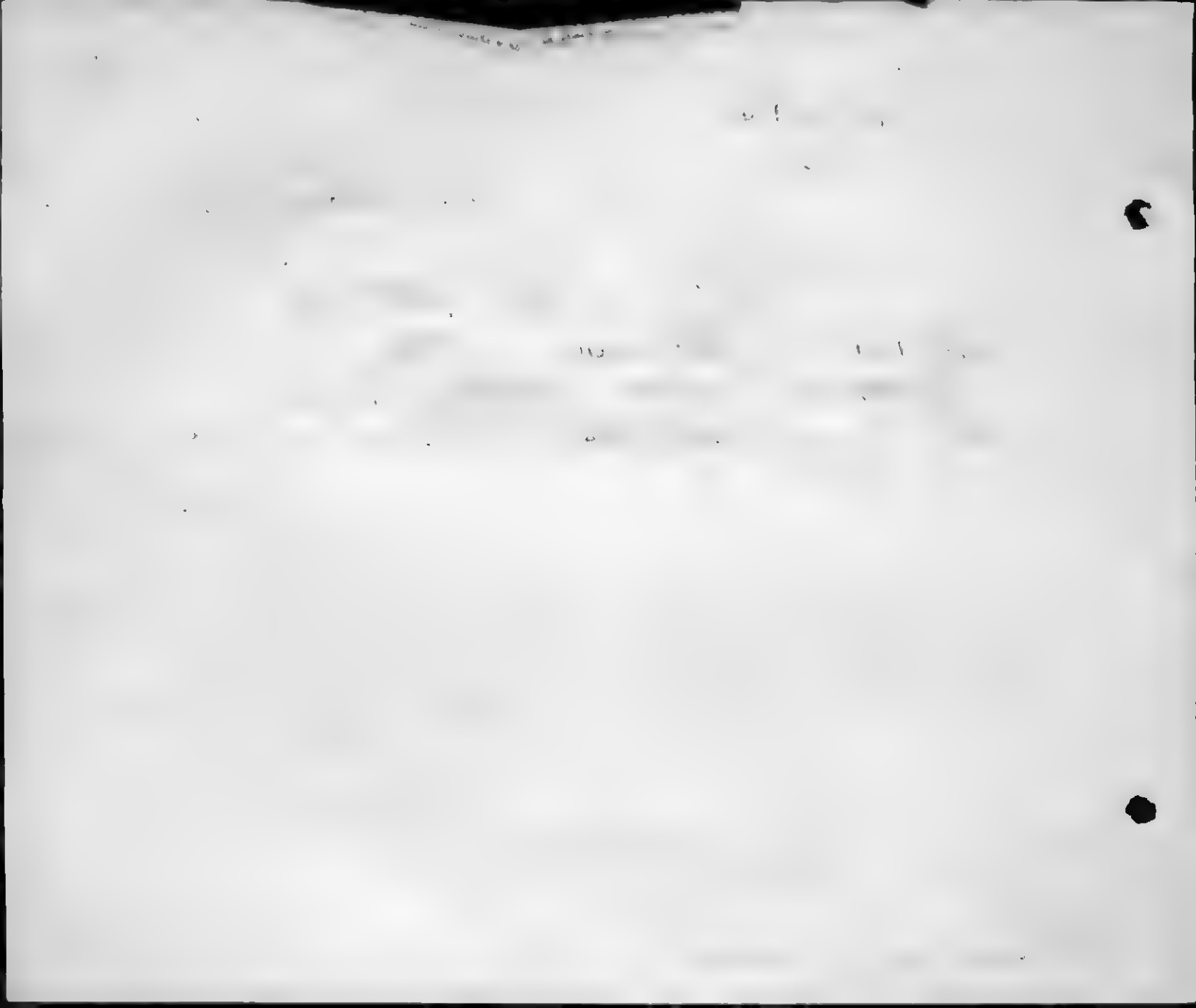
20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING CAUSE OF DEATH ☐ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian struck by car
20c. TIME OF INJURY Month, Day, Year 12-28-1965 20d. INJURY OCCURRED While ☐ Not While ☒ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street 20f. (City or town) Pocomoke (County) Somerset (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐ inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Philip A. Insley M.D. CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) Philip A. Insley ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒ Address (Street, city, town, or county) 12-28-68

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 12-31-65 22c. NAME OF CEMETERY OR CREMATORY Georgetown Cem. 22d. LOCATION (City, town, or county) Pocomoke City, Md.

23. FUNERAL DIRECTOR Samuel Savage ADDRESS New Church, Va. 24a. REC'D BY REGISTRAR J. Charles Judge 24b. REGISTRAR'S SIGNATURE J. Charles Judge
DATE JAN 3 1966

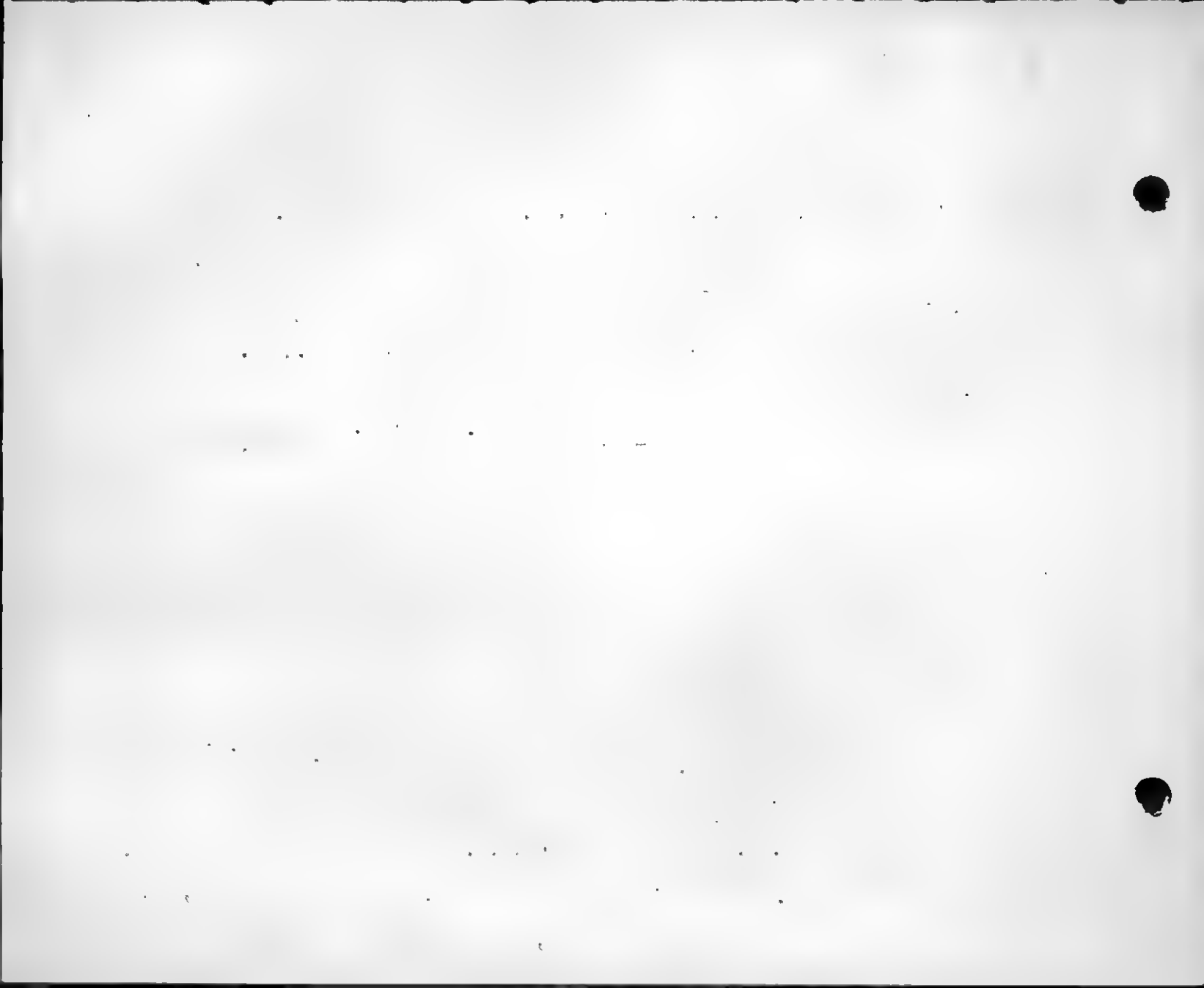


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
17125 CERTIFICATE OF DEATH 507

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 2 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Deer's Head State Hospital, Salisbury, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 239 Lincoln Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Russell Middle Milton Last Cropper		4. DATE OF DEATH Month Dec. Day 2 Year 19 65	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 22/1913
9. AGE (in years last birthday) 52 yrs.		IF UNDER 1 YEAR Months 7 Days 10	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Trucking	11. BIRTHPLACE (County & State, or foreign country) Worcester Co., Md.
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Mott Cropper	
14. MOTHER'S MAIDEN NAME Minnie Mitchell		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. 220-10-8123		17. INFORMANT Mrs. Dorcas P. Cropper (Wife) 239 Lincoln Ave (Ext) Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant brain tumor (removed) DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH Months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Nov. 30, 19 65 to Dec. 2, 19 65 , that (I) (we) last saw the deceased alive on Dec. 2, 19 65 , and that death occurred at 5:20 PM from the causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 12/2/65	
22c. PHYSICIAN'S NAME (Type) C. F. Gutierrez-Garrido, M.D.		22d. ADDRESS Deer's Head State Hospital, Salisbury	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 5/1965	23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	23d. LOCATION (City, town or county) (State) Salisbury, Maryland
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY		25a. REC'D BY REGISTRAR DEC 6 1965	
25b. REGISTRAR'S SIGNATURE [Signature]			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

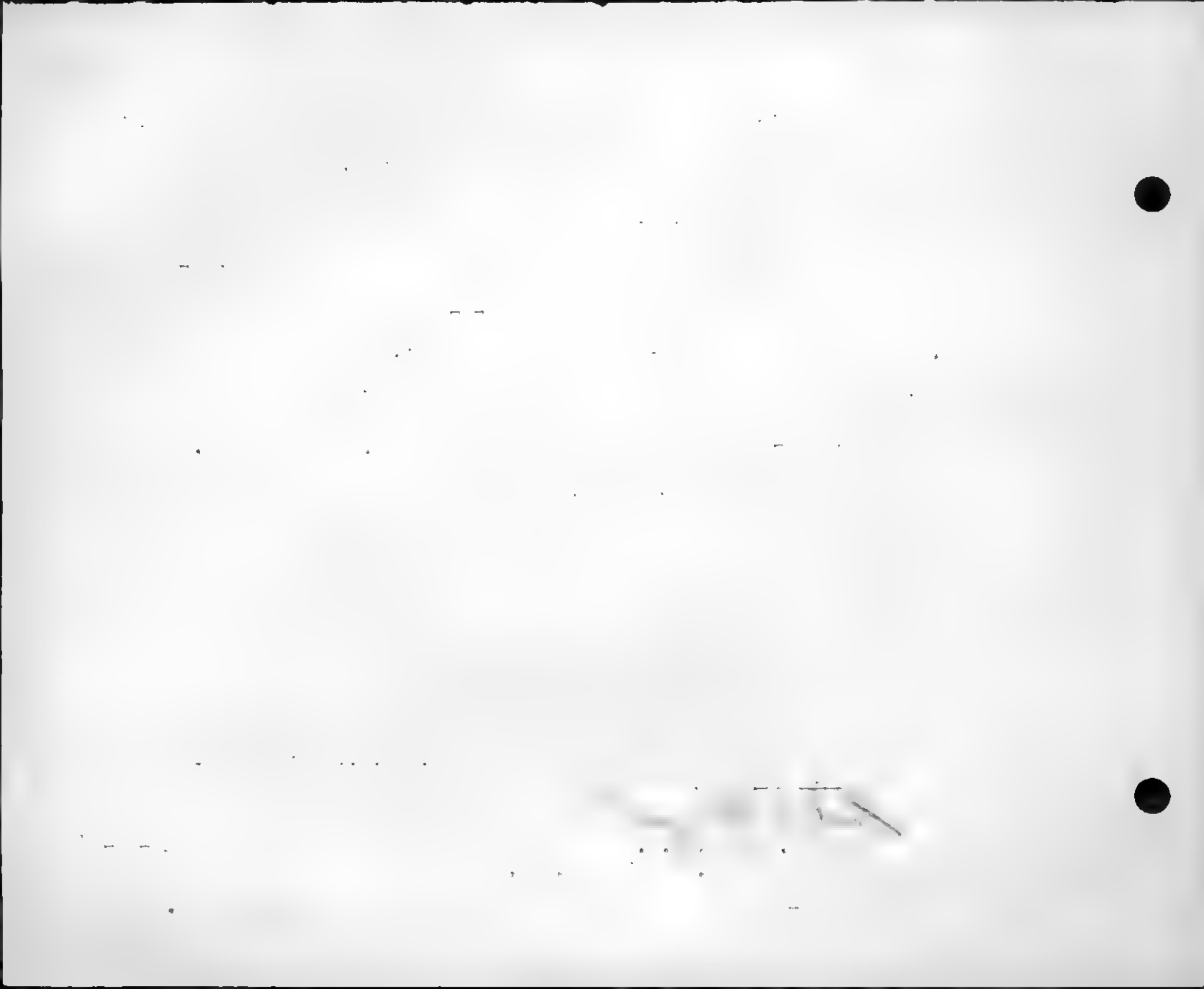
MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17126

20508

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN ID			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				e. STREET ADDRESS <u>8 West State Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>Melbourn</u> Last <u>Darby</u>				4. DATE OF DEATH Month <u>12</u> Day <u>22</u> Year <u>65</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <u>3-2-1895</u>	9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	b. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rt. Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Darby</u>				14. MOTHER'S MAIDEN NAME <u>Lida Vaughn</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Alice Darby, Delmar, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Earl L. Royer, M.D.</u>				22. DATE SIGNED <u>12-23-65</u>			
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				Address (Street, city, town, or county) <u>409 Camden Ave., Salisbury, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-28-65</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hebron</u>	23d. LOCATION (City, town or county) (State) <u>Hebron, Md.</u>				
24. FUNERAL DIRECTOR <u>Charles W. Marvel, Delmar, Del.</u>				25a. REC'D BY REGISTRAR <u>DEC 27 1965</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

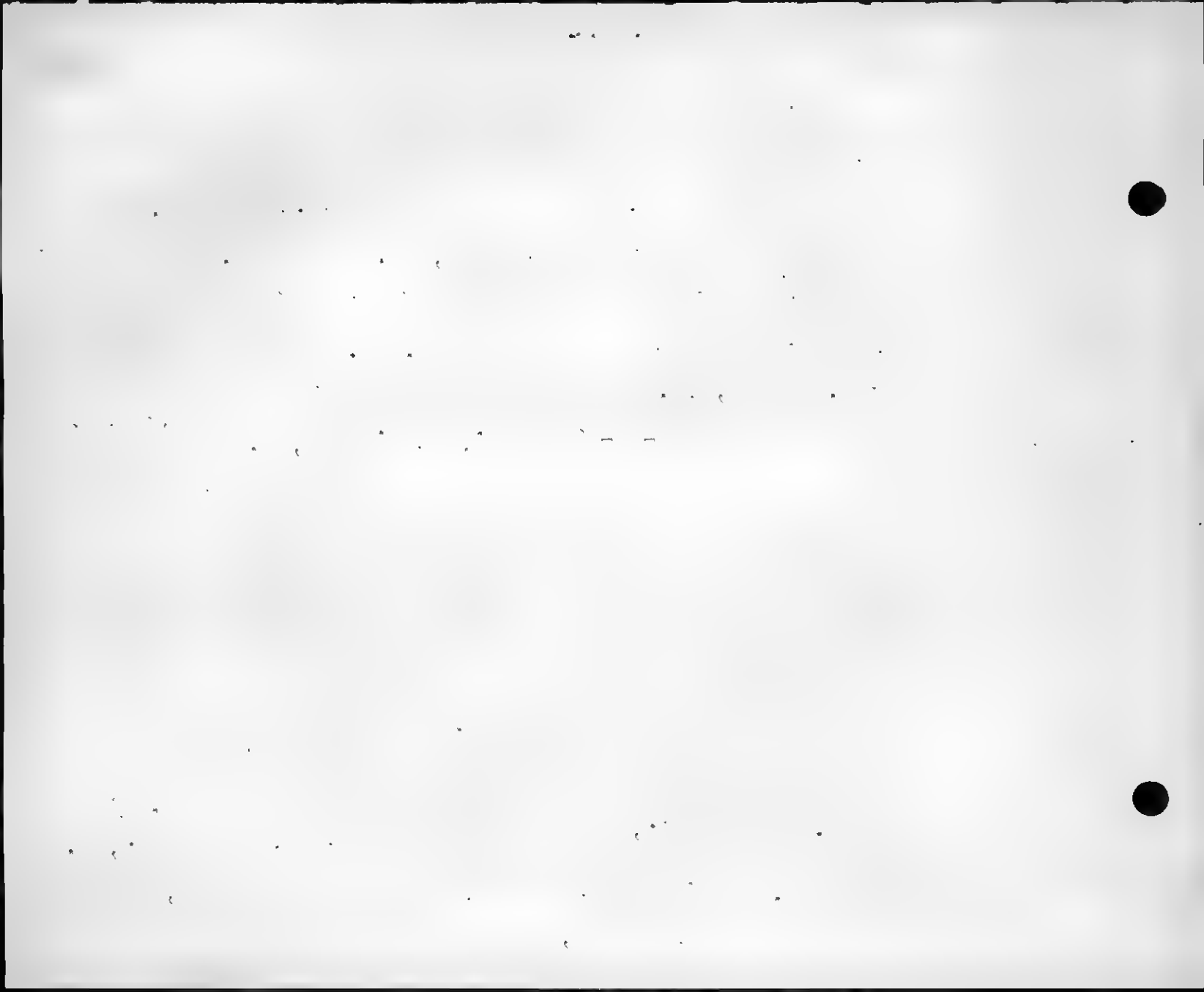
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

X

DR

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
17127
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 108 Princeton Ave		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 12 Salisbury d. STREET ADDRESS 108 Princeton Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSEPH KENNARD DARDINE, JR. First Middle Last		4. DATE OF DEATH Dec. 23 1965 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3/1902 9. AGE (In years last birthday) 63 yrs. IF UNDER 1 YEAR Months 6 Days 20 IF UNDER 24 HRS. Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager Finance Company		10b. KIND OF BUSINESS OR INDUSTRY Phila. Pa.	
11. BIRTHPLACE (County & State, or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Joseph K. Dardine, Sr.		14. MOTHER'S MAIDEN NAME Agnes Dardine Dardine	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 056-07-9089	
17. INFORMANT Mrs. Mary E. Dardine (Wife) Address 108 Princeton Ave. Salisbury, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Degenerative Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) 7/28/65 DUE TO (c) Interval between onset and death PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/28, 1965 , to 12/23, 1965 , that (I) (we) last saw the deceased alive on 12/23, 1965 , and that death occurred at 12/23, 1965 , from the causes and on the date stated above.			
22a. SIGNATURE Dr. Wilbur Ellis, Jr M.D.		22b. DATE SIGNED Dec. 27/1965	
22c. PHYSICIAN'S NAME (Type) Dr. Wilbur Ellis, Jr		22d. ADDRESS Medical Center Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 27/1965	23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	23d. LOCATION (City, town or county) (State) Salisbury, Maryland
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY ADDRESS SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR DEC 30 1965	25b. REGISTRAR'S SIGNATURE W. J. Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

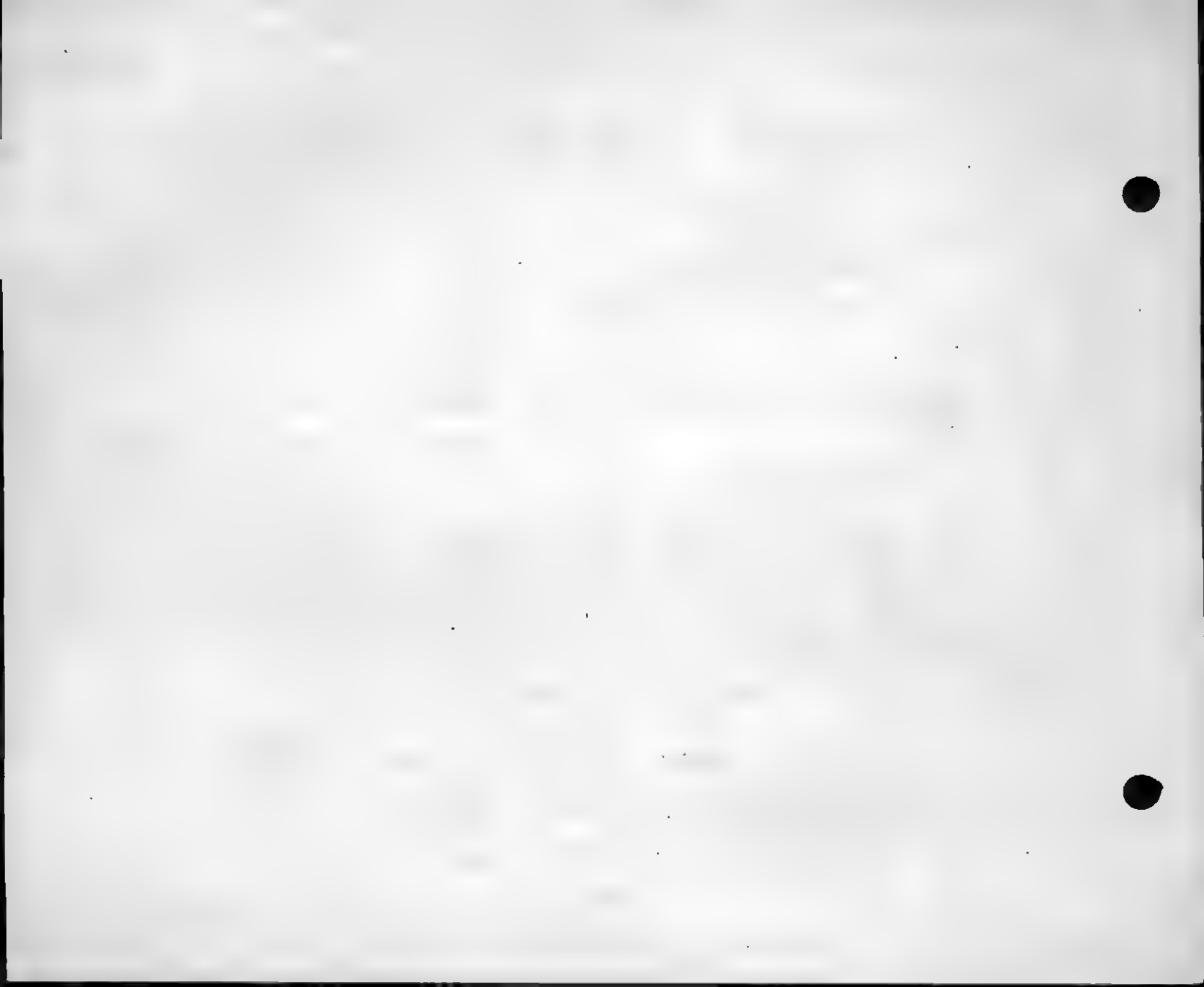
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VR A15 (4)
15M 4-64

17128

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>1 WK</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>White Haven, Md.</u>			
d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Dashiell</u> Last <u>Dashiell</u>				4. DATE OF DEATH Month <u>December</u> Day <u>8</u> Year <u>1965</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/13/1895</u>	
9. AGE (in years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Army Captain</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Harry Caplan</u>				14. MOTHER'S MAIDEN NAME <u>Sally Winder</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mary L. Dashiell, White Haven, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Empyema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic Lung Disease - old TB</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u> </u> (this hospital) attended the deceased from <u> </u> , 19 <u> </u> to <u> </u> , 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u> </u> , 19 <u>65</u> , and that death occurred at <u>7P</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Michael B. Flynn</u>				22b. DATE SIGNED <u>Dec 15, 1965</u>			
22c. PHYSICIAN'S NAME (Type) <u>Michael B. Flynn</u>				22d. ADDRESS <u>Peninsula General Hosp</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/12/65</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Family Cem.</u>		23d. LOCATION (City, town or county) (State) <u>White Haven, Md.</u>	
24. FUNERAL DIRECTOR <u>C. J. Messing, Biville, Md.</u>				25a. REC'D BY REGISTRAR <u>DEC 20 1965</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

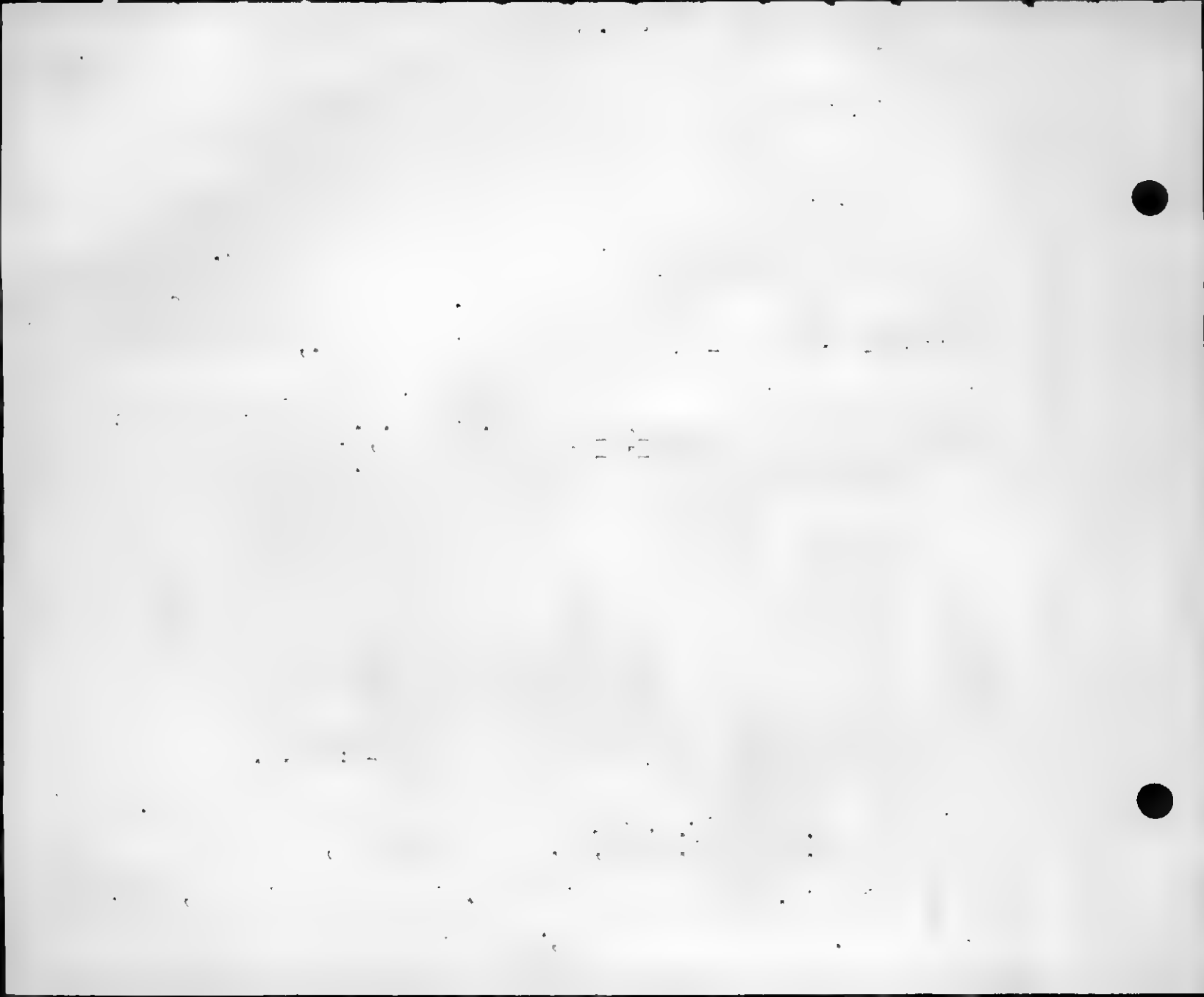


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

<div style="text-align: center;"> 1 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 17129 CERTIFICATE OF DEATH </div>												
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Quantico Road						d. STREET ADDRESS Quantico Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First ELIJAH Middle LINWOOD Last DAVIS			4. DATE OF DEATH Month DEC. Day 26th Year 1965			5. SEX Male			6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Feb. 22/ 1902			9. AGE (In years last birthday) 63 yrs.			10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Groceryman			10b. KIND OF BUSINESS OR INDUSTRY &-Poultryman			
11. BIRTHPLACE (County & State, or foreign country) Wicomico Co., Maryland			12. CITIZEN OF WHAT COUNTRY? U S A			13. FATHER'S NAME James Thomas Davis			14. MOTHER'S MAIDEN NAME Mary Jane Kelly			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 212-10-3940			17. INFORMANT Mrs. Mary E.C. Davis (Wife)			Address Quantico Rd Salisbury, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic epidermoid carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) primary site undetermined DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 3 MON.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 5-13 1965 to 12-13 1965 , that (we) last saw the deceased alive on 12-13 1965 , and that death occurred at App-7-35 P.M. from the causes and on the date stated above.												
22a. SIGNATURE Dr. Robert T. Adkins						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED Dec. 29/1965			
22c. PHYSICIAN'S NAME (Type) Dr. Hubert R. White, Jr.						22d. ADDRESS Fruitland, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Dec. 29/1965			23c. NAME OF CEMETERY OR CREMATORY Wicomico Mem. Park			23d. LOCATION (City, town or county) (State) Salisbury, Maryland			
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY						ADDRESS SALISBURY, MARYLAND			25a. REC'D BY REGISTRAR DEC 30 1965			
						25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>						



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 11

17130

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) b. STATE <u>Maryland</u> c. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>E. en</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>R.F.D. #2</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EVERETT</u> <u>ALVIN</u> <u>DENSON</u>				4. DATE OF DEATH Month <u>12</u> Day <u>12</u> Year <u>19 65</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 22, 1929</u>		9. AGE (In years last birthday) <u>36</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Baking</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rt. Supervisor</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US.A.</u>	
13. FATHER'S NAME <u>James E. Denson</u>				14. MOTHER'S MAIDEN NAME <u>Marie Malone</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>220-28-2228</u>		17. INFORMANT <u>Mrs. Juanita B. Denson, Same</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crowning Occlusion</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Dr. Earl L. Royer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-15-1965</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Siloam Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Siloam, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill Funeral Home Salisbury, Maryland</u>				24a. REC'D BY REGISTRAR <u>DEC 20 1965</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

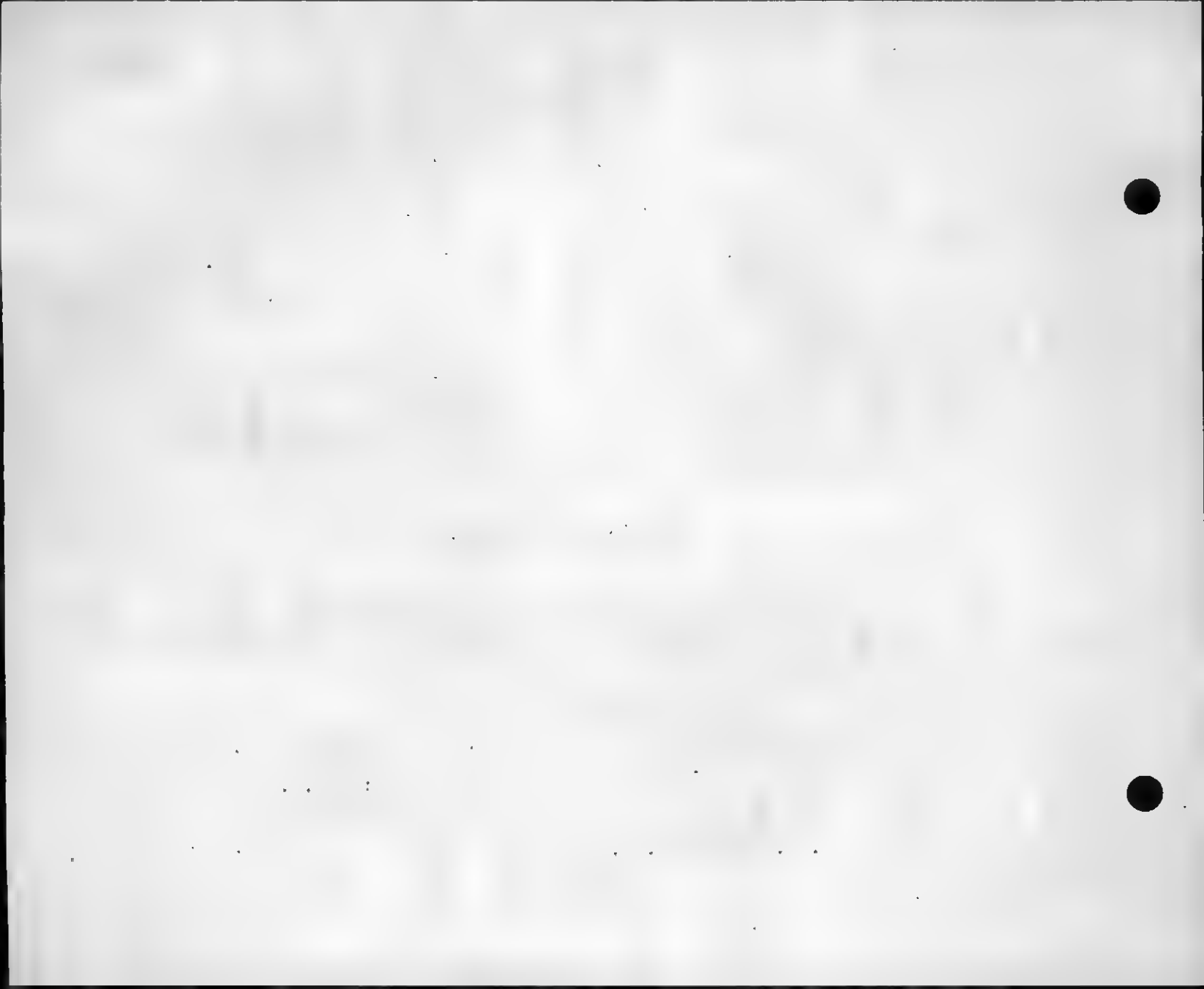
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17131

Item #7 Filed 12/12/65

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 6 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela Springs d. STREET ADDRESS Rt 2, Box 70 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Lula Middle Cindy Last Deshields		4. DATE OF DEATH Month Dec. Day 14 Year 19 65		5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-12-80		9. AGE (In years last birthday) 85 yrs. IF UNDER 1 YEAR: Months 1 Days 1 IF UNDER 24 HRS.: Hours 1 Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY none				11. BIRTHPLACE (County & State, or foreign country) MD		12. CITIZEN OF WHAT COUNTRY USA			
13. FATHER'S NAME John Waller				14. MOTHER'S MAIDEN NAME Martha Jenkins				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					
16. SOCIAL SECURITY NO. 332X				17. INFORMANT Geo Deshields				Address Deer's Head State Hospital					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Arteriosclerosis, general Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 332X DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH 2 weeks Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. 9:30 A.M. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that no (this hospital) attended the deceased from Dec. 8 , 19 65 , to Dec. 14 , 19 65 , that we last saw the deceased alive on Dec. 14 , 19 65 , and that death occurred at 9:30 A.M. M, from the causes and on the date stated above.													
22a. SIGNATURE W. Maldve				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED 12/14/65					
22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.				22d. ADDRESS Deer's Head Hospital, Salisbury, Md.									
23a. BURIAL, CREMATION, REMOVAL* (Specify) Burial				23b. DATE THEREOF 12-18-65		23c. NAME OF CEMETERY OR CREMATORY Mordelle Can		23d. LOCATION (City, town or county) (State) Mordelle MD					
24. FUNERAL DIRECTOR James M. West				ADDRESS		25a. REC'D BY REGISTRAR DATE 27 1965		25b. REGISTRAR'S SIGNATURE Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WICOMICO		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Snow Hill	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY		c. LENGTH OF STAY IN 1b 23 x 7	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PENINSULA General Hospital		d. STREET ADDRESS 409 COVINGTON	
3. NAME OF DECEASED (Type or print) First Middle Last Samuel E Dickerson		4. DATE OF DEATH Month Day Year December 10, 1965	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 25, 1906
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Chick Hatchery	
11. BIRTHPLACE (County & State, or foreign country) Snow Hill Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert T Dickerson		14. MOTHER'S MAIDEN NAME Alice Duncan	
15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-20-3790	
17. INFORMANT Sarah A. Sessoms, Snow Hill, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5705 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Acute vascular cellulitis DUE TO (c) Acute Intestinal Obstruction		INTERVAL BETWEEN ONSET AND DEATH 3 hrs 6 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec 9, 1965 to Dec 10, 1965 , that (I) (we) last saw the deceased alive on Dec 10, 1965 , and that death occurred at 10:25 PM , from the causes and on the date stated above.			
22a. SIGNATURE DAVID R. H. FAT		22b. DATE SIGNED 12/13/65	
22c. PHYSICIAN'S NAME (Type) DAVID R. H. FAT		22d. ADDRESS Snow Hill Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-14-65	23c. NAME OF CEMETERY OR CREMATORY Friendship Cemetery	23d. LOCATION (City, town or county) (State) Snow Hill Maryland
24. FUNERAL DIRECTOR Ernest F. Harris, Snow Hill, Md.		25. REC'D BY REGISTRAR DEC 15 1965	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

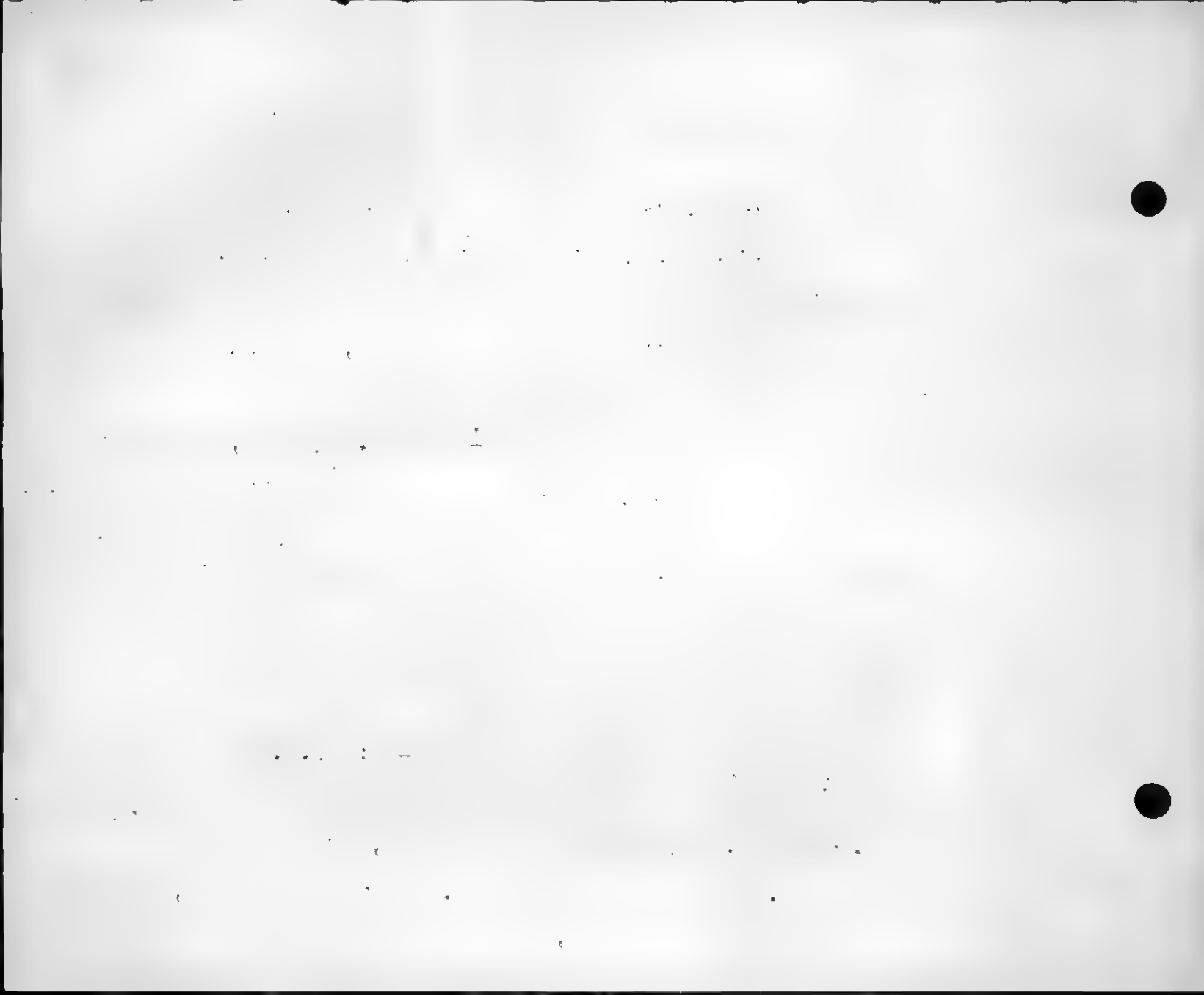
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mardela c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Maple Shade Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron d. STREET ADDRESS Main Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BESSYE Middle ELIZABETH Last DISHAROON		4. DATE OF DEATH Month DEC. Day 25 Year 1965	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 12/1883
9. AGE (In years last birthday) 82 yrs. Months 5 Days 13 Hours 13 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME George Dove		14. MOTHER'S MAIDEN NAME Margaret Perry	
15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 0	
17. INFORMANT Mrs. Elizabeth Navarro (Daughter) Address 4th-66th St. New York, New York			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 DUE TO Acute Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis C.A. DUE TO Dis (c) Arteriosclerosis generalized		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from App-10-30 P.M. 19 65 , that (I) (we) last saw the deceased alive on 19 65 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE Dr. George G. Schlesinger		22b. DATE SIGNED Dec 28/1965	
22c. PHYSICIAN'S NAME (Type) Dr. George G. Schlesinger		22d. ADDRESS Mardela, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 29/1965	
23c. NAME OF CEMETERY OR CREMATORY Springhill Mem. Gardens		23d. LOCATION (City, town or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY		25a. REC'D BY REGISTRAR DEC 30 1965	
ADDRESS SALISBURY, MARYLAND		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

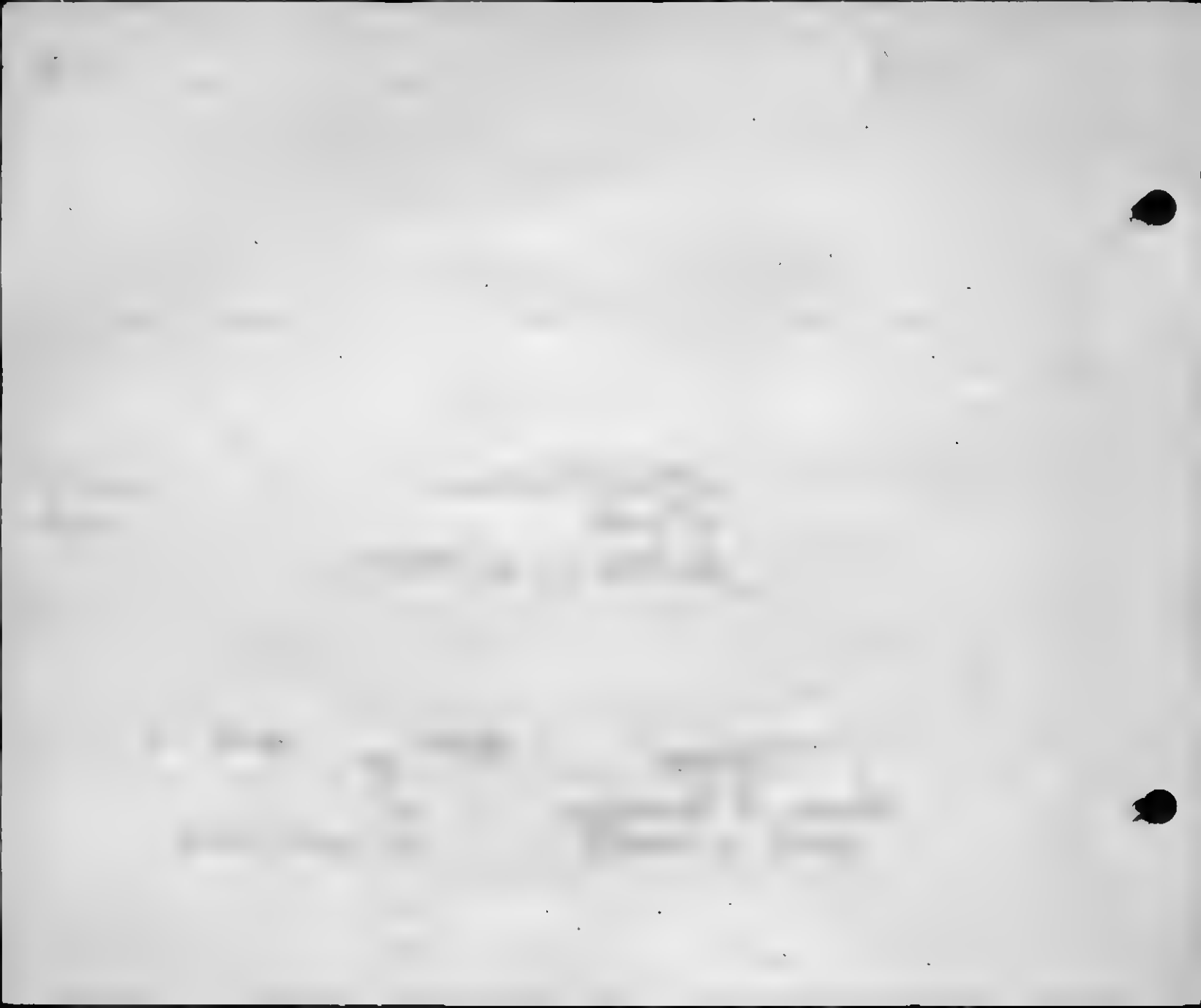
CERTIFICATE OF DEATH

17134

16

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tyaskin</u> d. STREET ADDRESS <u>R.F.D.</u>			
3. NAME OF DECEASED (Type or print) <u>Arthur C. Farrington</u>				4. DATE OF DEATH Month <u>12</u> Day <u>28</u> Year <u>1965</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/3/1891</u>	
9. AGE (In years last birthday) <u>74</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Famer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James Farrington</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				17. INFORMANT <u>Esther D. Farrington, Tyaskin, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>CVA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Arterio-sclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/1/65</u>, to <u>12/28/65</u>, that (I) (we) last saw the deceased alive on <u>12/28/65</u>, and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>James J. Kidney</u>				22b. DATE SIGNED <u>12/28/65</u>			
22c. PHYSICIAN'S NAME (Type) <u>James J. Kidney</u>				22d. ADDRESS <u>Bivalue, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/2/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Newtown Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Tyaskin, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Pospisil, Bivalue, Maryland</u>				25a. REC'D BY REGISTRAR <u>DATE N 3 1966</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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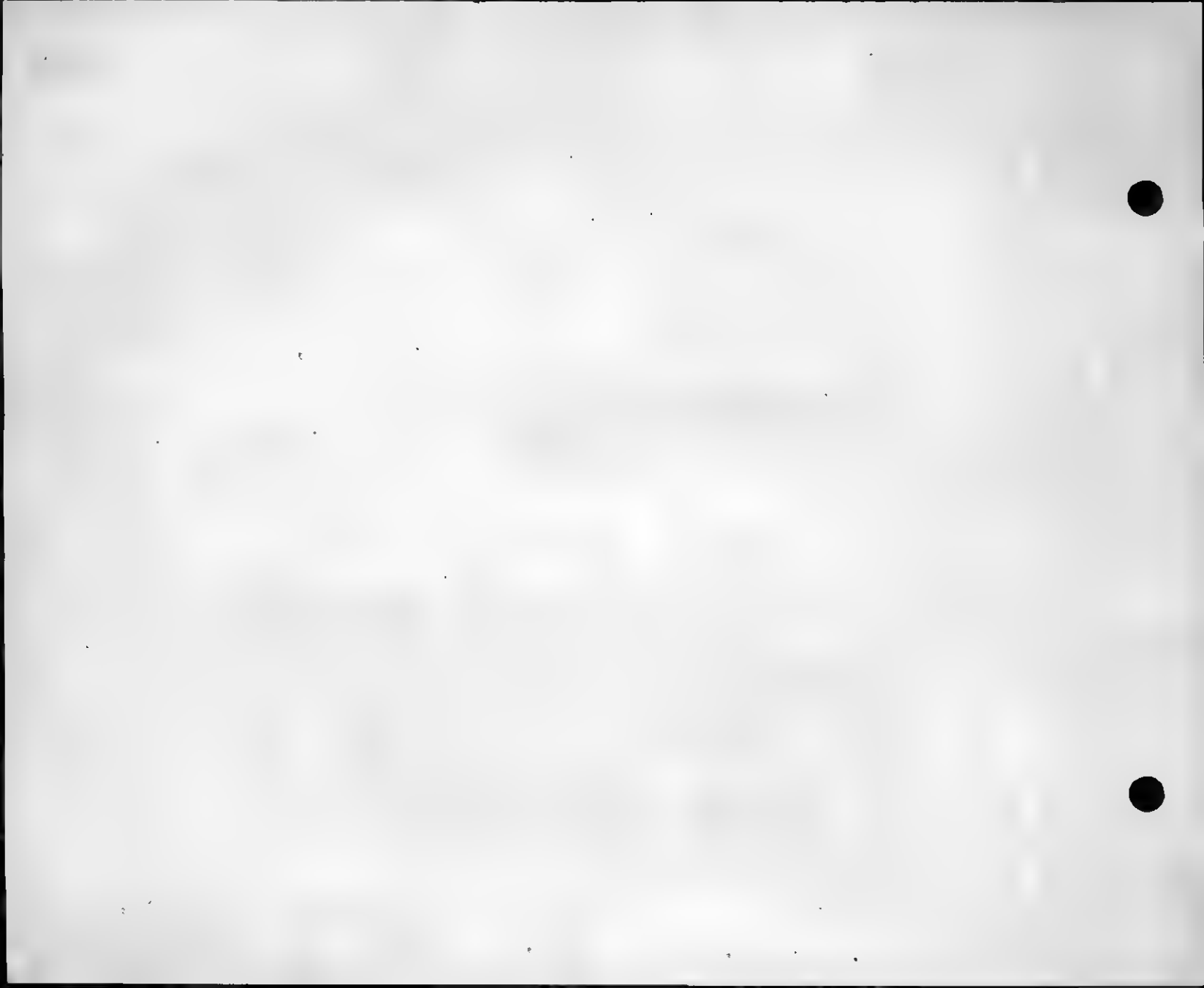
<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Md.</u> c. LENGTH OF STAY IN 1b <u>17135</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>DELAWARE</u> b. COUNTY <u>SUSSEX</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>DELMAR</u> d. STREET ADDRESS <u>RURAL</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>JOHN WALTER Figg</u> First Middle Last				4. DATE OF DEATH <u>December 4 1965</u> Month Day Year				5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u> 11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				9. AGE (in years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.				8. DATE OF BIRTH <u>6-29-1893</u>			
13. FATHER'S NAME <u>STONLEY FIGGS</u> 14. MOTHER'S MAIDEN NAME <u>MARY JANE MADDOX</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>221-14-4346</u> 17. INFORMANT <u>Sela Figg, Delmar self</u> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Bronchopneumonia</u> (b) <u>Adenocarcinoma of prostate with metastases</u> (c) <u>metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>11 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from <u>11-28-65</u>, 19<u>65</u> to <u>12-4-65</u>, 19<u>65</u>, that (1) (we) last saw the deceased alive on <u>12-4-65</u>, 19<u>65</u>, and that death occurred at <u>3:30</u> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>Raymond M. Giv</u>						22b. DATE SIGNED <u>12-6-65</u>		22c. PHYSICIAN'S NAME (Type) <u>Medical Center Salisbury, Md.</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12-7-65</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MELSON</u>		23d. LOCATION (City, town or county) (State) <u>DELMAR - MD</u>		25a. REC'D BY REGISTRAR <u>DEC 9 1965</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
24. FUNERAL DIRECTOR <u>Charles W. Giv</u> <u>Delmar, Del</u>											



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
17136 CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Somerset</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>						c. LENGTH OF STAY IN 1b <u>Life Time</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PENINSULA General Hospital</u>						d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print) <u>Robert Lee Fisher Jr.</u>						4. DATE OF DEATH <u>December 1, 1965</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>I/21/61</u>		9. AGE (In years last birthday) <u>4</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Princess Anne, Md</u>				12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Robert L Fishers</u>						14. MOTHER'S MAIDEN NAME <u>Ruth Hutt</u>					
15. WAS DECEASED EVER IN U.S. ARMY OR NAVY? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <u>Ruth Fisher Princess Anne, Maryland</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>EMPHYSEMA</u> DUE TO (b) <u>SUB-DIAPHRAGMATIC - ABSCESS - RI</u> DUE TO (c) <u>RUPTURED APPENDIX</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED while <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>10 Nov 1965</u> to <u>Dec 1, 1965</u> , that (I) (we) last saw the deceased alive on <u>December 1, 1965</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>W. Jay Reur</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22b. DATE SIGNED <u>3 Dec 65</u>					
22c. PHYSICIAN'S NAME (Type) <u>Medical Center, Salisbury, Md</u>						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF <u>12/5/65</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St Mary</u>				23d. LOCATION (City, town or county) (State) <u>West Post Office, MD</u>	
24. FUNERAL DIRECTOR <u>William H. James Jr. Princess Anne, Md</u>						25a. REC'D BY REGISTRAR <u>DEC 6 1965</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



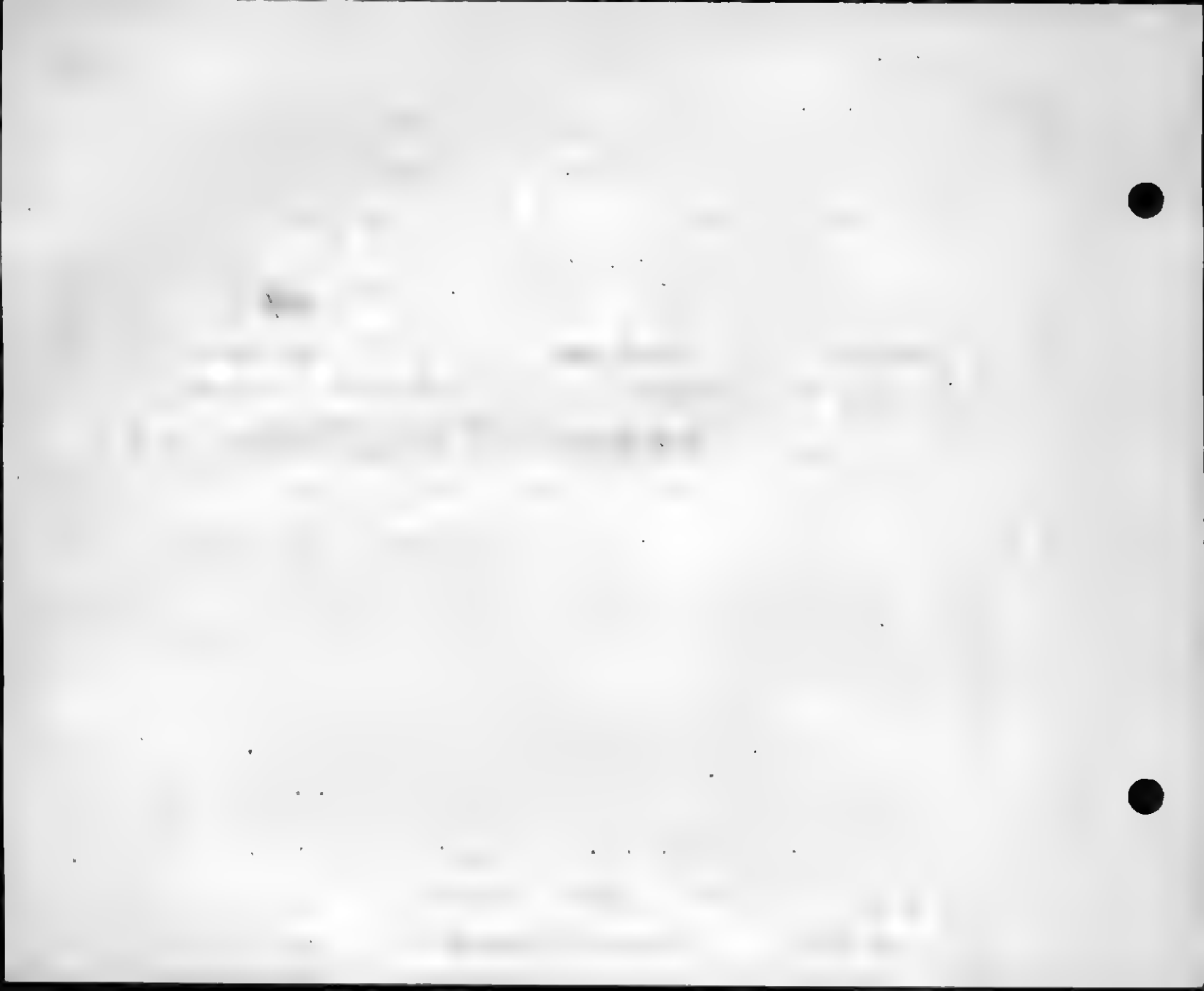
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 175 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown d. STREET ADDRESS 120 Cannon Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Marian Middle Elizabeth Last Floyd		4. DATE OF DEATH Month December Day 6 Year 1965	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/15/1905 69 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR		10b. KIND OF BUSINESS OR INDUSTRY VAR. OGS	
11. BIRTHPLACE (County & State, or foreign country) KENTCO. MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME JOHN MURRAY		14. MOTHER'S MAIDEN NAME SENIE UNK.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-18-4747	
17. INFORMANT MRS. VIRGINIA CANN CHESTER TOWN, MD		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recurrent cerebral thrombosis due to 443x DUE TO (b) Hypertensive arteriosclerotic cardiovascular Years — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c) disease	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that to (this hospital) attended the deceased from June 14 , 19 65 , to Dec. 6 , 19 65 , that to (we) last saw the deceased alive on Dec. 6 , 19 65 , and that death occurred at — M, from the causes and on the date stated above.			
22a. SIGNATURE L. V. Maldve		22b. DATE SIGNED 11:58 P.M. 12/7/65	
22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.		22d. ADDRESS Deer's Head Hospital, Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 12/11/65	23c. NAME OF CEMETERY OR CREMATORY JAMES CEMETERY	23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR James W. Wally		25a. REC'D BY REGISTRAR DEC 9 1965	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

MEDICAL CERTIFICATION

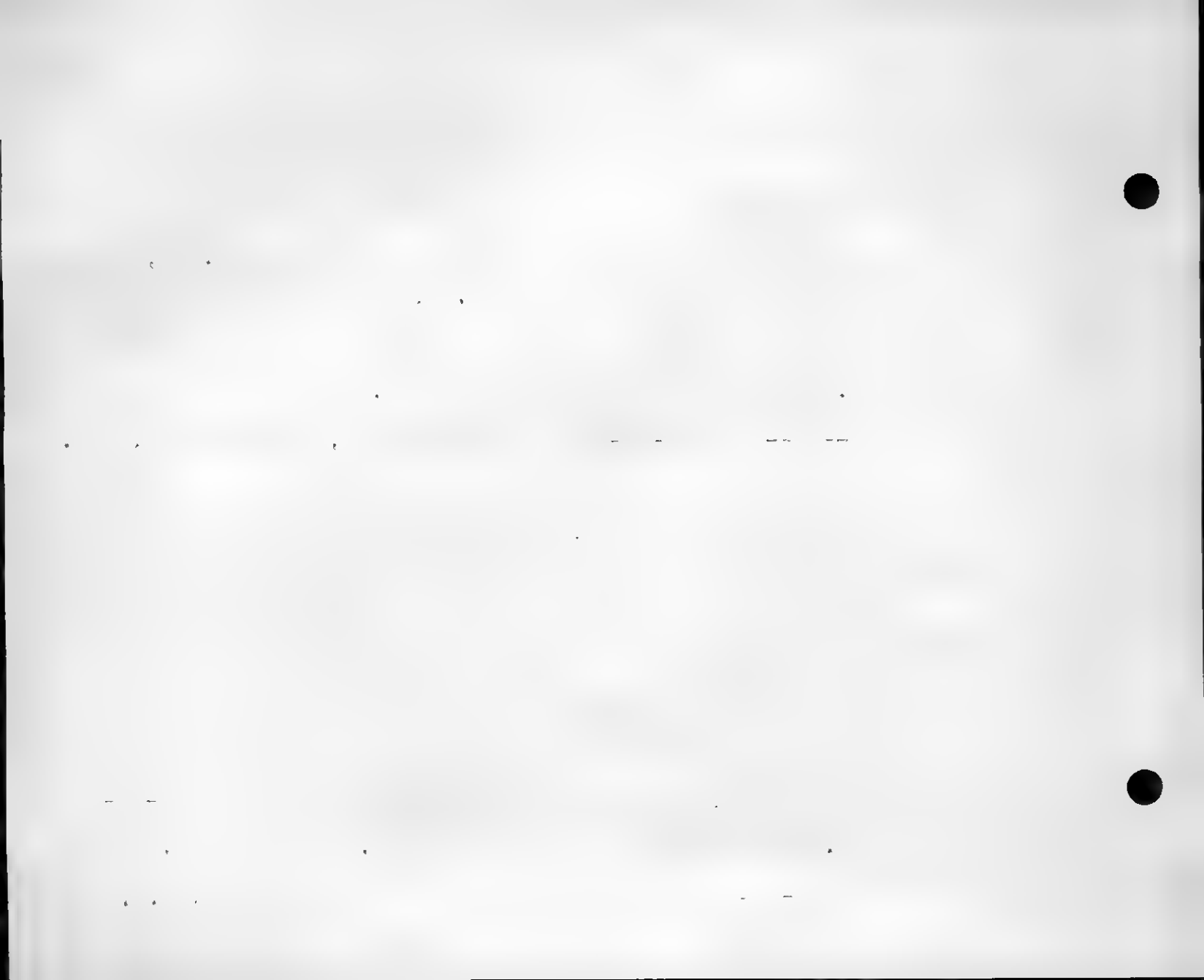


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
17138
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar c. LENGTH OF STAY IN 1b 5 yrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 211 Spruce Street		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar d. STREET ADDRESS 211 Spruce e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDITH Middle EMILY Last FRERIE		4. DATE OF DEATH Month Dec. Day 18, Year 19 65	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 29, 1897
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Willard G. Spicer		14. MOTHER'S MAIDEN NAME Mary D. Parker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) -----		16. SOCIAL SECURITY NO. 577-42-8769	
17. INFORMANT Irene Culver, 211 Spruce St., Md.		Address Delmar	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X cerebral hemorrhage DUE TO (b) arteriosclerosis DUE TO (c) arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 20 min. Known.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/1, 19 18 to dark , 19 65 , that (I) (we) last saw the deceased alive on Dec 16, 19 65 , and that death occurred at 4:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE Dr. Ernest Larmore		22b. DATE SIGNED 12-20-65	
22c. PHYSICIAN'S NAME (Type) Dr. Ernest Larmore		22d. ADDRESS Grove St. Delmar, Del.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-21-65	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln,		23d. LOCATION (City, town or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR Charles W. Marvel - Delmar, Del		25a. REC'D BY REGISTRAR DEC 22 1965	
25b. REGISTRAR'S SIGNATURE Charles Judge			

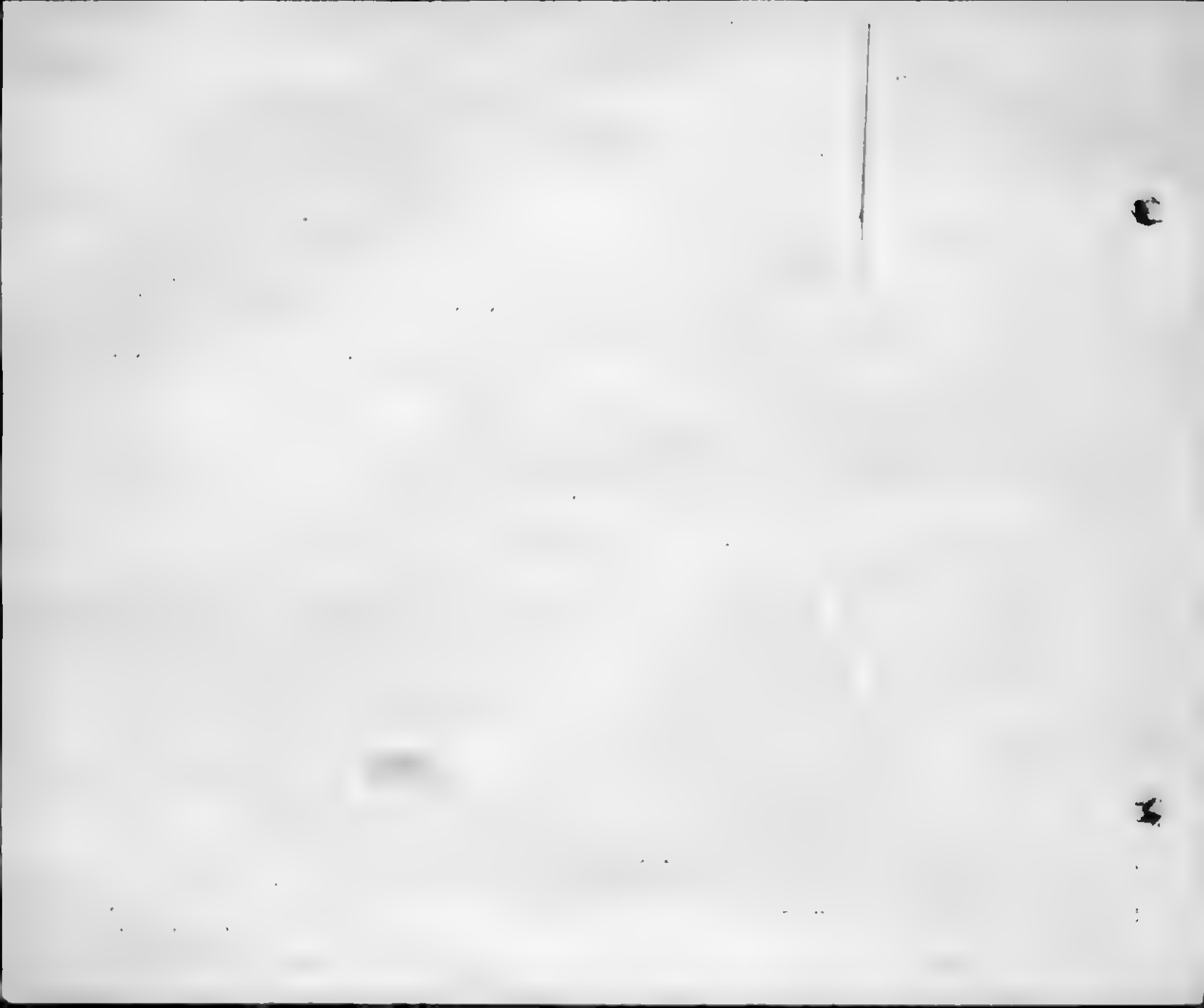


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VR AIS (4)
ISM 7, 61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delmar</u>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <u>Woodland Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CARRIE</u>		4. DATE OF DEATH Month <u>12</u> Day <u>18</u> Year <u>65</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>AA</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 8, 1913</u>	
9. AGE (In years last birthday) yrs. <u>52</u>		IF UNDER 1 YEAR: Months <u>12</u> Days <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Laurel, Del.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Elzey</u>		14. MOTHER'S MAIDEN NAME <u>Polly Whitney</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>222-10-5435</u>	
17. INFORMANT <u>Pearl Dashiell</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic C.A.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>C.A. of Pancreas</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH months			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>8-23</u>, 19<u>56</u>, to <u>12-18</u>, 19<u>65</u>, that (I) (we) last saw the deceased alive on <u>12-18</u>, 19<u>65</u>, and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Earl L. Royer</u>			
22c. PHYSICIAN'S NAME (Type) <u>Earl L. Royer, M.D.</u>			
22d. ADDRESS <u>409 Camden Ave., Salisbury, Md.</u>			
22e. DATE SIGNED <u>12-20-65</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
23b. DATE THEREOF <u>12-23-65</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Woodland Cemetery</u>			
23d. LOCATION (City, town or county) (State) <u>Delmar Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Booker West</u>			
25a. REC'D BY REGISTRAR <u>Charles Judge</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the pages, 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>10 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>82 Peninsula General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>Accomack</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GREENBACKVILLE</u> d. STREET ADDRESS <u>-</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>TURNER</u> Last <u>SIDNEY</u> 4. DATE OF DEATH <u>December 3</u> 19 <u>65</u>		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>MARCH 14</u> 18 <u>79</u> 9. AGE (In years last birthday) <u>86</u> yrs. 10. IF UNDER 1 YEAR Months Days Hours Min. 11. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FREIGHT AGENT</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u> 11. BIRTHPLACE (County & State, or foreign country) <u>PENNSYLVANIA</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>UNKNOWN</u> 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>UNKNOWN</u> 16. SOCIAL SECURITY NO. <u>UNKNOWN</u> 17. INFORMANT <u>MRS LEROY MOORE</u> Address <u>1946 RISING SUN LANE WILMINGTON DELAWARE</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Atherosclerosis</u> (c) <u>-</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>11-23</u> , 19 <u>65</u> , to <u>12-3</u> , 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>12-3</u> 19 <u>65</u> , and that death occurred at <u>4:45</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>James L. Clifford</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>JAMES L. CLIFFORD, M.D.</u> 22d. ADDRESS <u>Medical Center Salisbury MD</u>		22b. DATE SIGNED <u>DEC 10 1965</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>12-8-1965</u> 23c. NAME OF CEMETERY OR CREMATORY <u>UNION GREENBACKVILLE</u> 23d. LOCATION (City, town or county) (State) <u>WORCESTER County MARYLAND</u>		24. FUNERAL DIRECTOR <u>Robert H. Watson</u> ADDRESS <u>Pocomoke City, MD.</u> 25a. REC'D BY REGISTRAR <u>DEC 10 1965</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



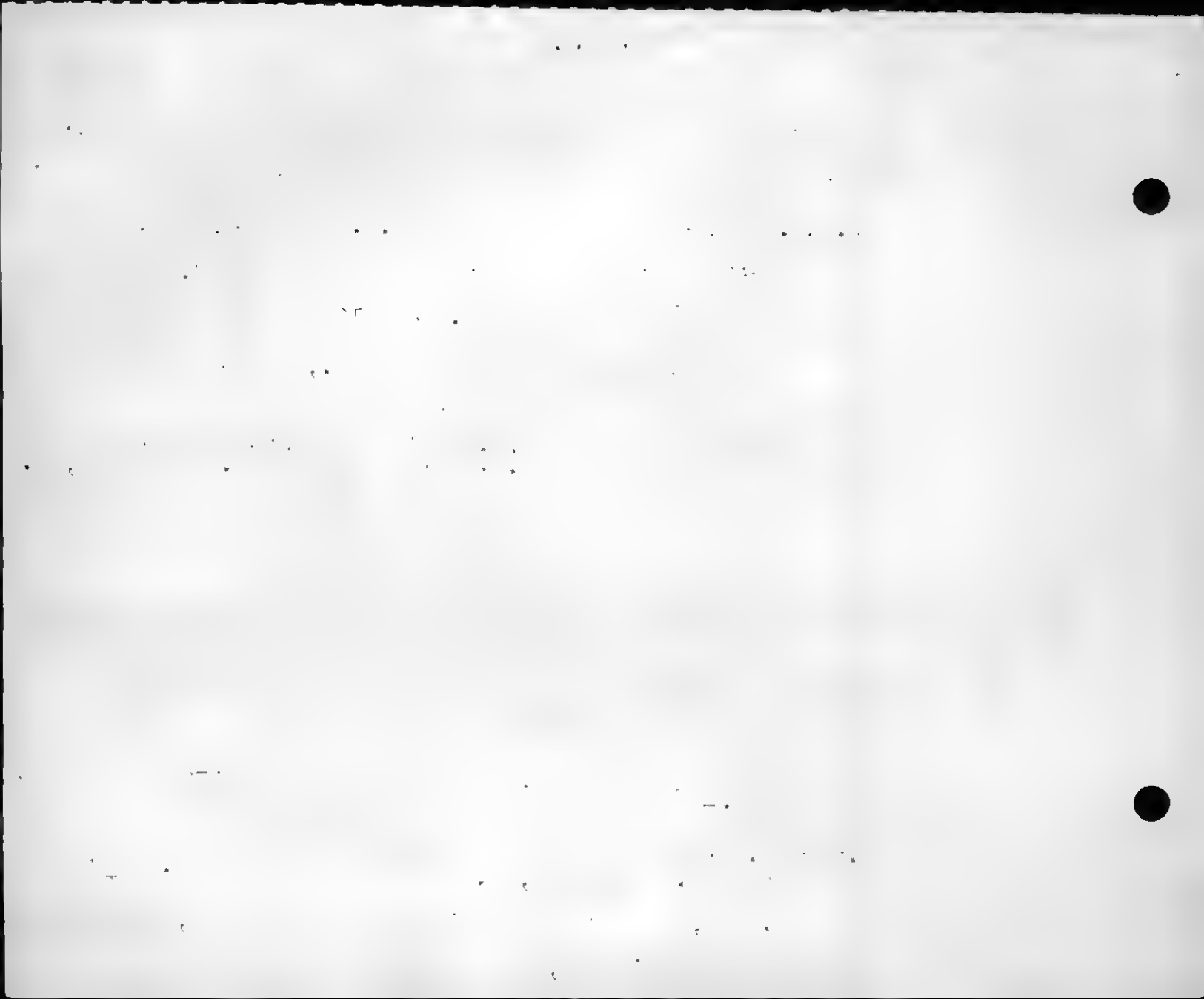
1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

17141
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pen. Gen. Hospital		e. STREET ADDRESS R.D.#3 Old Zion Church Rd.		e. IS RESIDENCE ON A FARM? <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last SAMUEL GORDON HEARNE		4. DATE OF DEATH Month Day Year X DEC. 23 19 65			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 24/1923	9. AGE (in years last birthday) 52 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min. 3 29
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Wicomico Co., Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Theodore Samuel Hearne		14. MOTHER'S MAIDEN NAME Etta White	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Mabel Truitt Hearne (Wife) R.D.#3 Zion Church Rd. Salisbury, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4501 Coronary Occlusion DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH minutes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Dr. Earl L. Royer		M.D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED Dec. 27 / 1965	
EXAMINER'S NAME (Type) 409 Camden Ave. Salisbury, Md.		Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 28/65		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	
23d. LOCATION (City, town or county) Salisbury, Maryland		23e. (State) Maryland			
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY		ADDRESS SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR DEC 28 1965	
				25b. REGISTRAR'S SIGNATURE Charles Judge	



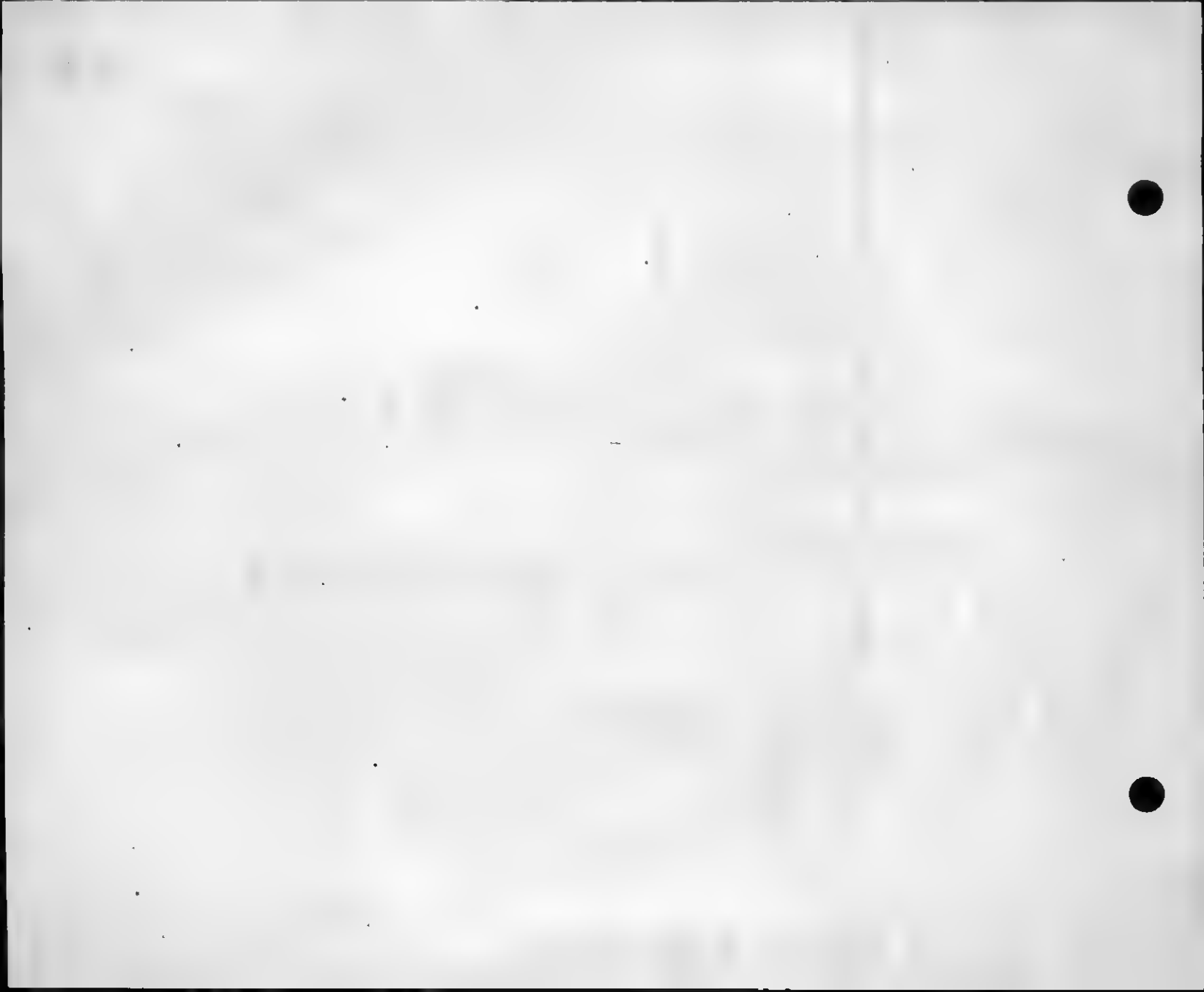
IN HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>2 1/2</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bishop</u> d. STREET ADDRESS <u>RFD</u>		6. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Cashar</u> Middle <u>F.</u> Last <u>Hickman</u>		4. DATE OF DEATH Month <u>December</u> Day <u>18</u> Year <u>1965</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 12, 1890</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Pemberton Hickman</u>		14. MOTHER'S MAIDEN NAME <u>Dollie Ann Bunting</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>XX</u> (If yes give war or dates of service) <u>XX</u>		16. SOCIAL SECURITY NO. <u>220-34-9787</u>		17. INFORMANT Address <u>Helen Hickman Bishop, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>Distal Hernia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Distal Hernia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>1965</u> to <u>12/15</u> , 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>12/17</u> , 19 <u>65</u> , and that death occurred at <u>6:30</u> M, from the causes and on the date stated above.					
22a. SIGNATURE <u>Rufus S. Gardner, Jr.</u>		M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/18/65</u>	
22c. PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER, JR.</u>		22d. ADDRESS <u>MEDICAL CENTER, SALISBURY, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/21/65</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows</u>	
23d. LOCATION (City, town or county) <u>Bishopville, Md.</u>		(State)			
24. FUNERAL DIRECTOR'S ADDRESS <u>John Whaley Salisbury, Del.</u>		25a. REC'D BY REGISTRAR <u>DEC 22 1965</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



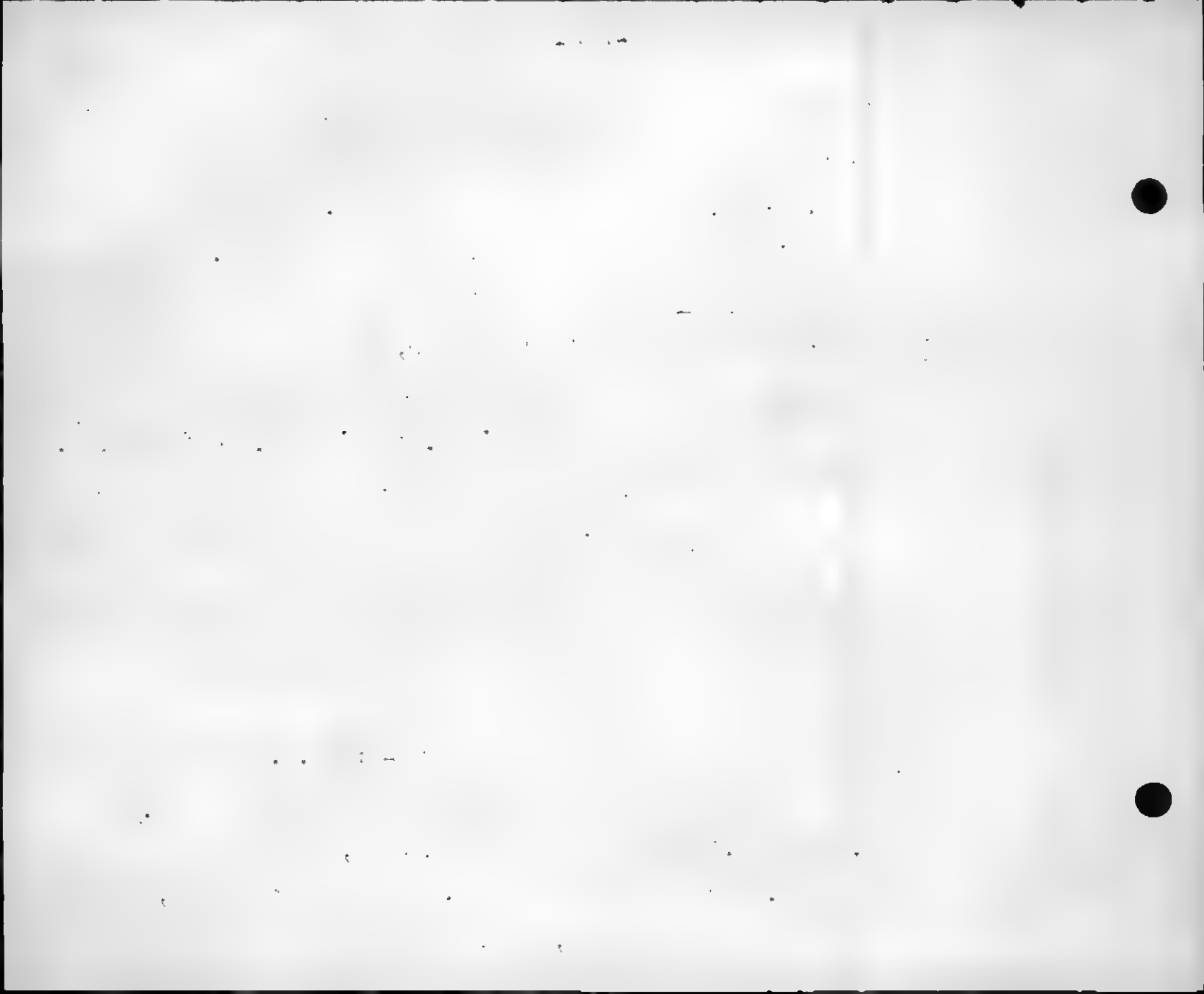
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 610 S.Division St					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 610 S.Division St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) ADA		First ADA		Middle ANNIE		Last HOLLOWAY		4. DATE OF DEATH Month DEC. Day 30 Year 19 65	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 9/1879		9. AGE (In years last birthday) 86 yrs. IF UNDER 1 YEAR: Months 5 Days 21 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Shirt Factory "Operator"				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Delmar, Delaware		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME George Hastings					14. MOTHER'S MAIDEN NAME Mary Hastings Hastings				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Frances B. Parker (Wife-Daughter) 610 S.Division St., Salisbury, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis +201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH 2 minutes years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 1964 to Dec 30, 1965 , that (I) (we) last saw the deceased alive on Dec 1, 1965 , and that death occurred at 4:30 PM from the causes and on the date stated above.									
22a. SIGNATURE Robert T. Adkins						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Dec. 31 /1965	
22c. PHYSICIAN'S NAME (Type) Dr. Robert T. Adkins						22d. ADDRESS Fruitland, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 3/1965		23c. NAME OF CEMETERY OR CREMATORY Forest Grove Cemetery		23d. LOCATION (City, town or county) (State) Parsonsborg, Maryland			
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY						ADDRESS SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR JAN 3 1966	
						25b. REGISTRAR'S SIGNATURE f Charles Judge			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any case within 72 hours after death.

VR AISM
5M 1/62

Item 20a-20f Film G372 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17144 1/13/66 TT

1. PLACE OF DEATH
a. COUNTY **Wicomico** MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Salisbury**
c. LENGTH OF STAY in 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **Peninsula General Hosp.**

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE **Md.** b. COUNTY **Worcester**
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Rural - Pocomoke**
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print)
First Middle Last
James Henry Horsey

4. DATE OF DEATH
Month Day Year
Dec. 27 1965

5. SEX **Male** 6. COLOR OR RACE **Negro** 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH
Dec. 1, 1907 58 yrs.

9. AGE (In years last birthday) IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Laborer** 10b. KIND OF BUSINESS OR INDUSTRY **Factory** 11. BIRTHPLACE (State or foreign country) **Va.** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **Robert Cornish** 14. MOTHER'S MAIDEN NAME **Mary Horsey**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **No** 16. SOCIAL SECURITY NO. 17. INFORMANT **Mary Horsey Pocomoke City, Md.**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Compound Fracture Skull**
8134 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO
(b) (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) **Fract left tibia + fibula**

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Struck by car while on Bicycle

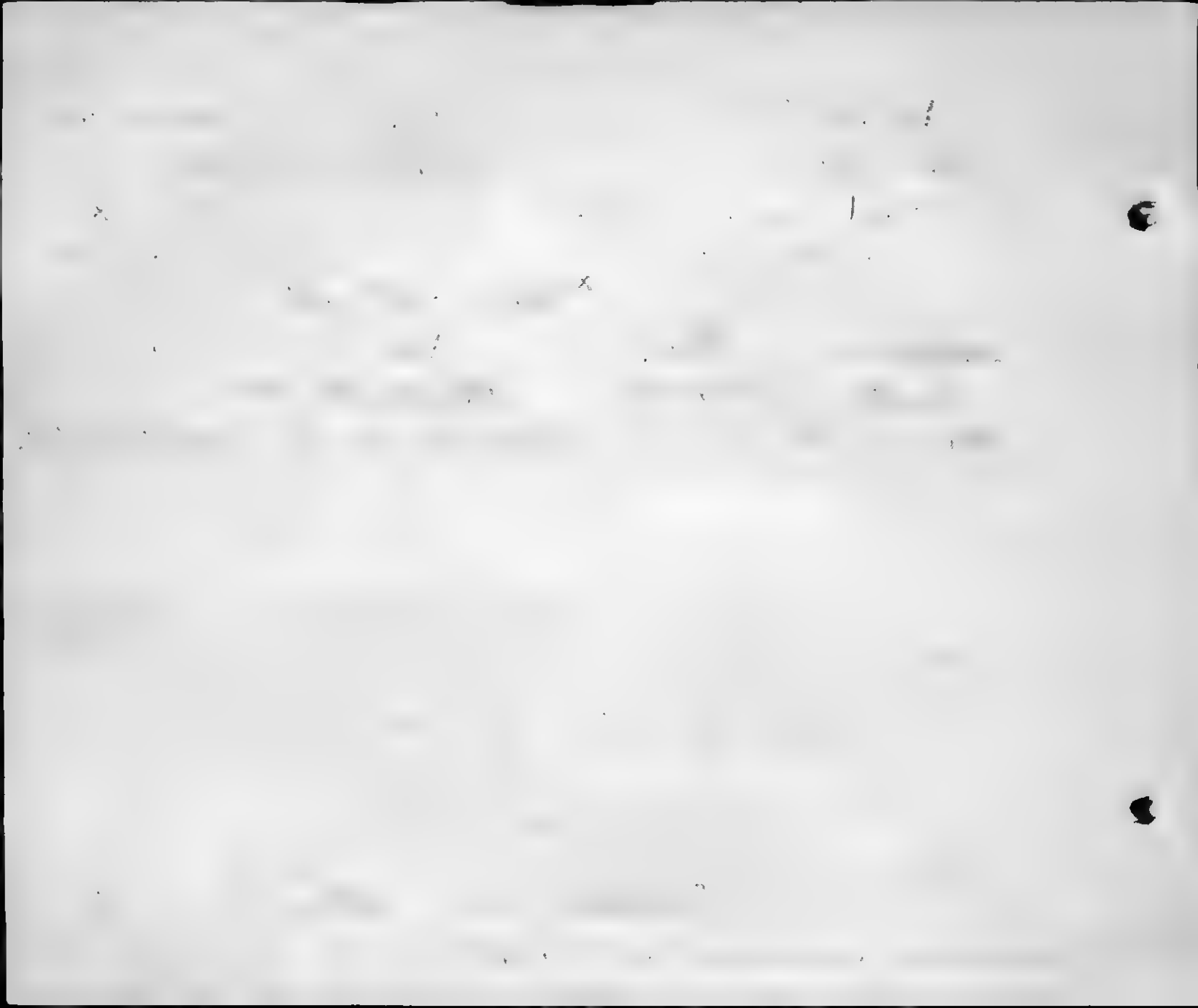
20c. TIME OF INJURY Month, Day, Year Hour **7:05** p.m. **12/27/65** 20d. INJURY OCCURRED While at work ☐ Not While at work ☒ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **Rt 13 nr. Pocomoke Pocomoke** (County) **Wicomico** (State) **Md.**

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Charles Judge** EXAMINER'S NAME (Type) **Charles Judge** CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ DATE SIGNED **12-28-65**

22a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 22b. DATE THEREOF **1-2-66** 22c. NAME OF CEMETERY OR CREMATORY **Friendship Cem.** 22d. LOCATION (City, town, or country) (State) **Wattsville, Va.**

23. FUNERAL DIRECTOR **Samuel Savage** ADDRESS **New Church, Va.** 24a. REC'D BY REGISTRAR **JAN 3 1966** 24b. REGISTRAR'S SIGNATURE **Charles Judge**



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

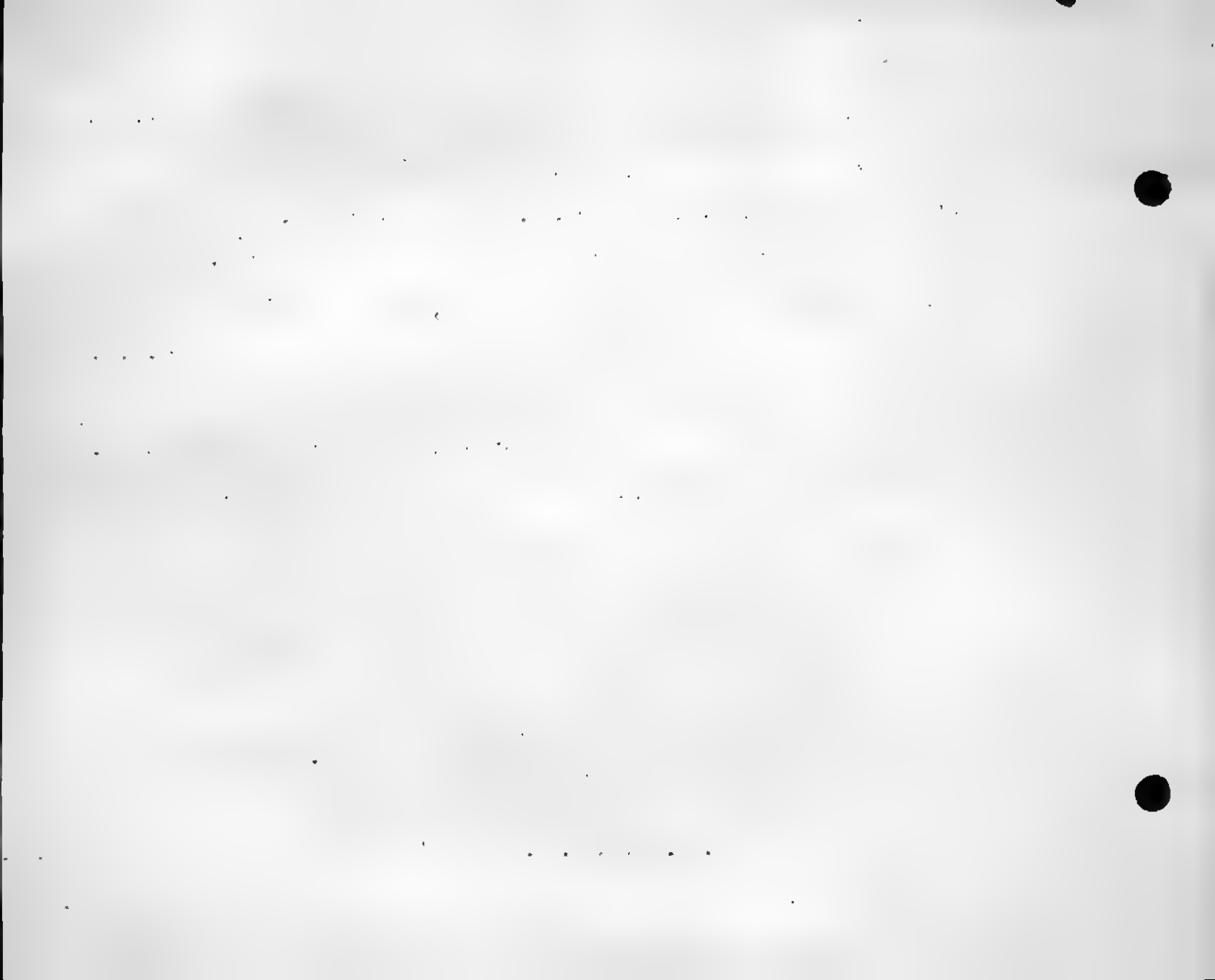
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

17145

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury	
c. LENGTH OF STAY IN 1b 23 Days		d. STREET ADDRESS 228 Delaware Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Deer's Head State Hospital, Salisbury, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alice Middle Elsie Last Jones		4. DATE OF DEATH Month Dec. Day 22 Year 19 65	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 6, 1900
9. AGE (In years last birthday) 65 Yrs.		10. IF UNDER 1 YEAR Months 65 Days 65 Hours 65 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Jones		14. MOTHER'S MAIDEN NAME Annie Dashiell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 102 Catherine St.	
17. INFORMANT Minnie Cottman		Address Salis Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of cervix uteri with metastases 171X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 1 yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11/29, 1965 to 12/22, 1965 , that (I) (we) last saw the deceased alive on 12/22, 1965 , and that death occurred at 12:15 PM , from the causes and on the date stated above.			
22a. SIGNATURE <i>V. Juerman</i>		22b. DATE SIGNED 12/22/65	
22c. PHYSICIAN'S NAME (Type) V. Juerman, M. D.		22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/26/1965	23c. NAME OF CEMETERY OR CREMATORY Green Acres	23d. LOCATION (City, town or county) (State) Salisbury Md.
24. FUNERAL DIRECTOR <i>Walter Stewart</i>		25a. REC'D BY REGISTRAR DEC 29 1965	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH

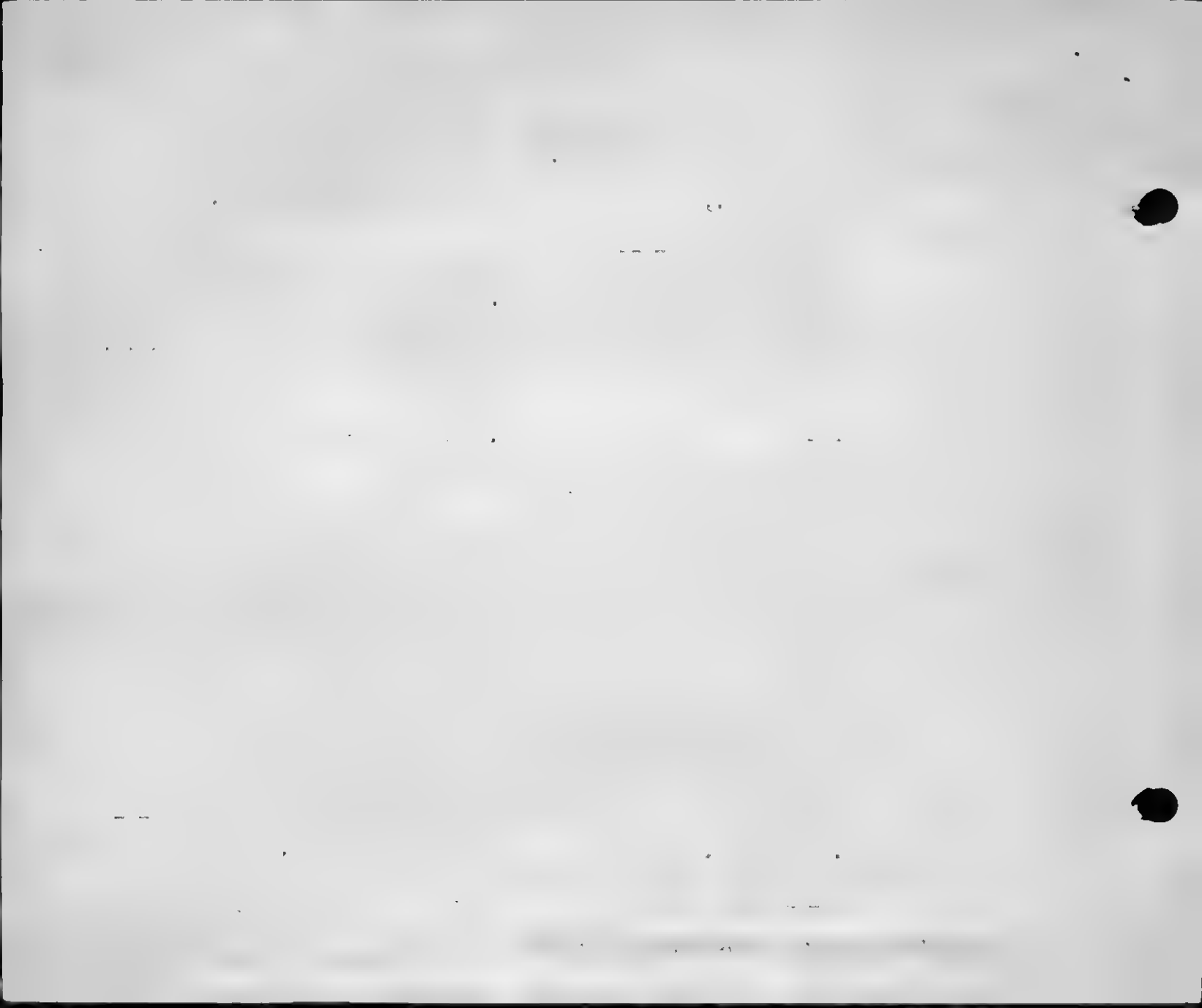
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

17146

1520

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>42 Y rs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1104 Riverside Dr.,</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>1104 Riverside Dr.,</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>LOUIS</u> Middle <u>---</u> Last <u>KLEGER</u>		4. DATE OF DEATH Month <u>12</u> Day <u>3</u> Year <u>19 65</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 22, 1900</u>		9. AGE (In years last birthday) <u>65</u> yrs. IF UNDER 1 YEAR Months <u>---</u> Days <u>---</u> IF UNDER 24 HRS. Hours <u>---</u> Min. <u>---</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grocers Retail</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Store Owner</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Unknown RUSSIA</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Kleger</u>						14. MOTHER'S MAIDEN NAME <u>Unknown</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Y s</u>		17. INFORMANT Address <u>Mrs. Louis Kleger, Same</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Coronary artery disease</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) <u>---</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>---</u>												INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>---</u> p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 1960</u> to <u>Dec 3, 1965</u> , that (I) (we) last saw the deceased alive on <u>Nov 1965</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.													
22a. SIGNATURE <u>William D. Gray</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12-3-1965</u>					
22c. PHYSICIAN'S NAME (Type) <u>Dr. William D. Gray</u>						22d. ADDRESS <u>334 Camden Ave., Salisbury, Maryland</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>12-3-1965</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Beth Irsael Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Salisbury, Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Sol Levinson Bur. Inc</u>						ADDRESS <u>6010 Cedarbrook Rd</u>		25a. REC'D BY REGISTRAR <u>DEC 9 1965</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

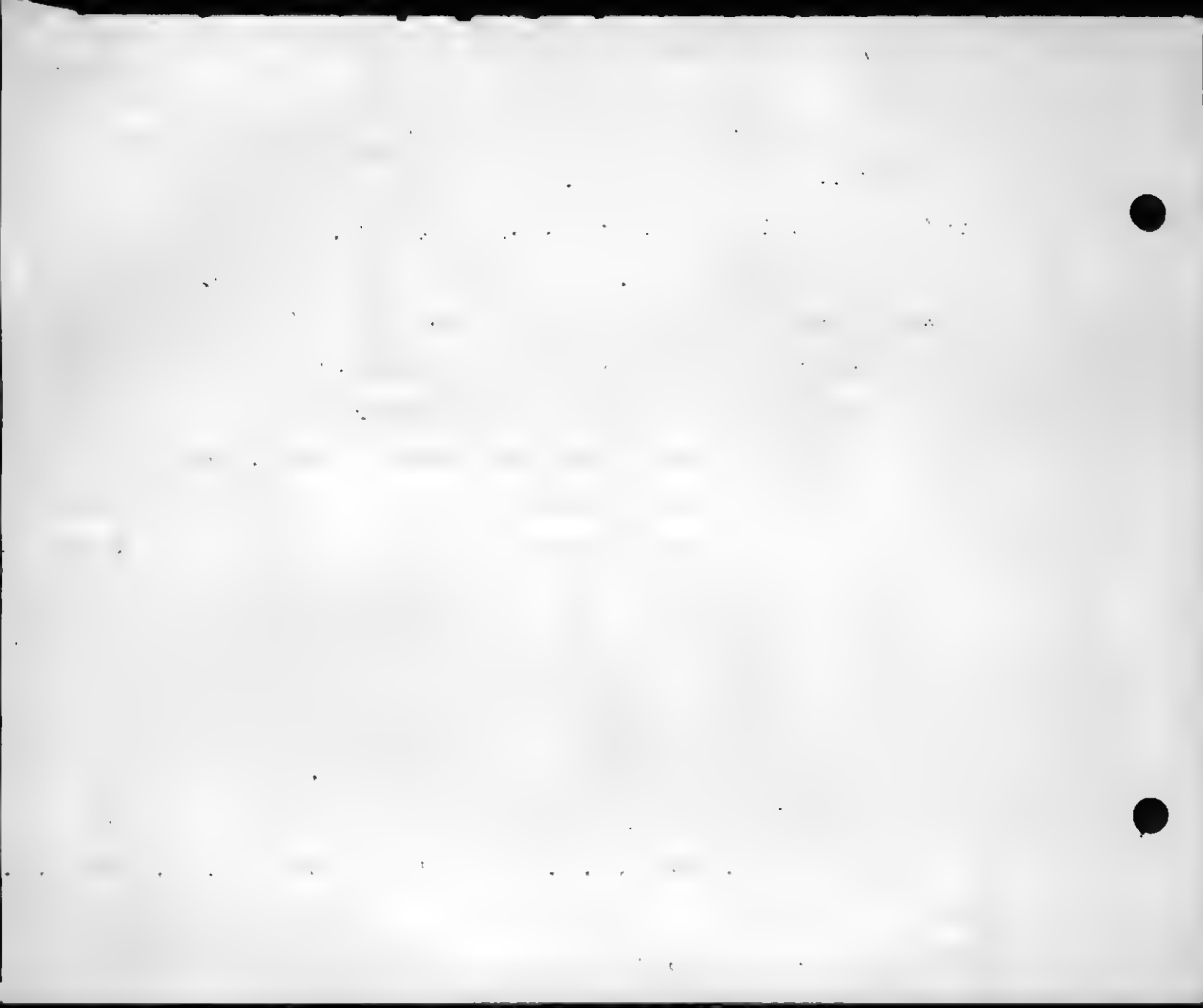


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VR A15 (4)
20M 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>																									
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 444 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Deer's Head State Hospital, Salisbury, Md.					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crisfield d. STREET ADDRESS 334 Cove St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																				
3. NAME OF DECEASED (Type or print) Ola B. Landon			4. DATE OF DEATH Month Dec. Day 5 Year 19 65		5. SEX Female			6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>															
8. DATE OF BIRTH 1898 May 14, 1898			9. AGE (In years last birthday) 67 yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.					10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seafood Worker			10b. KIND OF BUSINESS OR INDUSTRY Seafood		11. BIRTHPLACE (County & State, or foreign country) Crisfield, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
IF UNDER 1 YEAR		IF UNDER 24 HRS.																							
Months	Days	Hours	Min.																						
13. FATHER'S NAME Sidney Tyler					14. MOTHER'S MAIDEN NAME Anna Horner																				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 215-05-8866		17. INFORMANT Ralph Landon, Same as 2. abcd																				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Recurrent cerebral vascular accident DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 5 days 5 days															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)																	
21. I certify that (I) (this hospital) attended the deceased from 9/17 , 19 64 , to 12/5 , 19 65 , that (I) (we) last saw the deceased alive on 12/5 , 19 65 , and that death occurred at 3:00 PM , from the causes and on the date stated above.																									
22a. SIGNATURE <i>V. Juerman</i>										22b. DATE SIGNED 12/6/65															
22c. PHYSICIAN'S NAME (Type) V. Juerman, M. D.					22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22f. ATTENDING PHYS. <input type="checkbox"/>																
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 12/8/65		23c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery			23d. LOCATION (City, town or county) (State) Crisfield, Maryland																	
24. FUNERAL DIRECTOR Bradshaw & Sons, Crisfield, Maryland					25a. REC'D BY REGISTRAR DEC 10 1965		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>																		



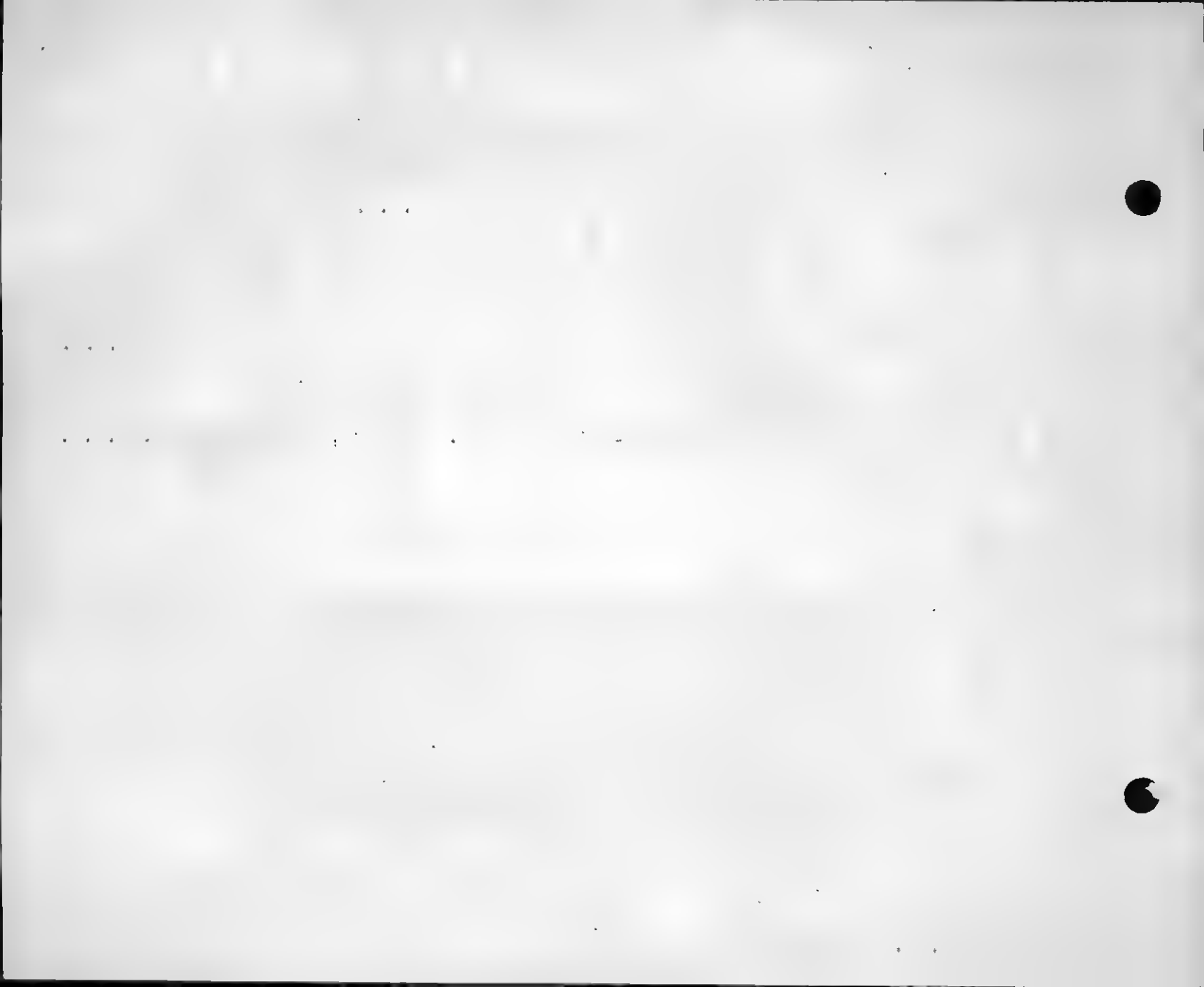
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DP

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>2 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rhodesdale</u> d. STREET ADDRESS <u>R.F.D.</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Hattie</u> First <u>Waters</u> Middle <u>Lankford</u> Last		4. DATE OF DEATH <u>December 10</u> 19 <u>65</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 22, 1896</u>		9. AGE (In years last birthday) <u>69</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Dorchester County, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>George Marine</u>						14. MOTHER'S MAIDEN NAME <u>Margaret Fisher</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>217-36-0518</u>		17. INFORMANT <u>Leon L. Lankford, Rhodesdale, Md. R.F.D.</u> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4200 Congestive Heart Failure and Pulmonary Edema</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>Years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus and Nephropathy</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>12/9/1965</u> to <u>12/10/1965</u> that (I) (we) last saw the deceased alive on <u>12/10/1965</u> and that death occurred at <u>10:15 A.M.</u> from the causes and on the date stated above.													
22a. SIGNATURE <u>[Signature]</u>						22b. DATE SIGNED <u> </u>							
22c. PHYSICIAN'S NAME (Type) <u> </u>						22d. ADDRESS <u> </u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>12/14/65</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Galestown Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Galestown, Maryland</u>			
24. FUNERAL DIRECTOR <u>J. J. Frampton and Son, Federalsburg, Md</u>						25a. REC'D BY REGISTRAR <u>DEC 20 1965</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					



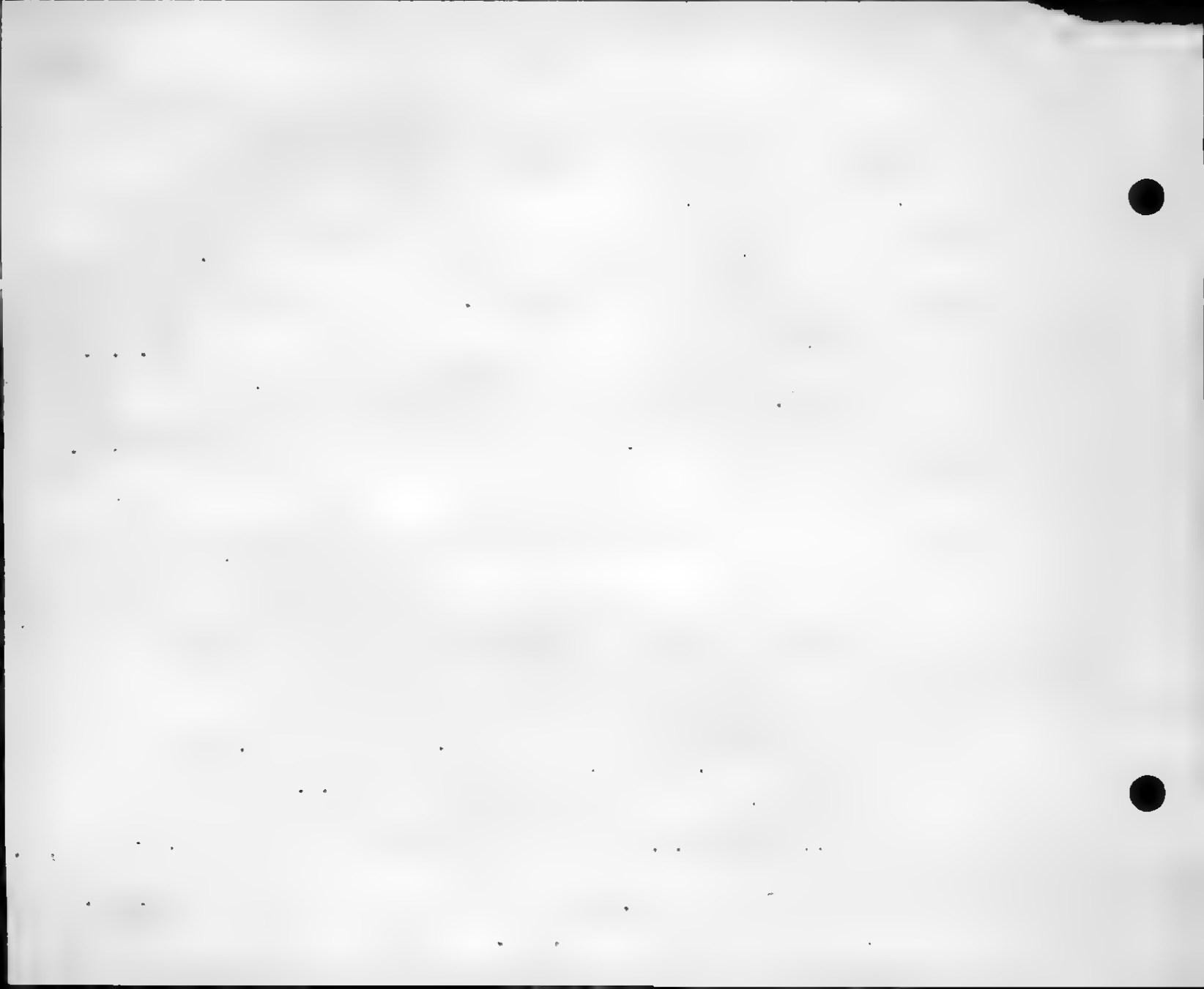
TO MORTUARY ON ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17149

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1531

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 15 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Deer's Head State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Somerset c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Eden d. STREET ADDRESS Route # 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alice Middle Mae Last Marshall		4. DATE OF DEATH Month Dec. Day 29 Year 19 65	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 18, 1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SIDNEY C. DRYDEN		14. MOTHER'S MAIDEN NAME SALLIE BRITTINGHAM	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS WALTER HALE		Address PRINCESS ANNE, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) Cerebral thrombosis with right hemiparesis and motor aphasia DUE TO (c) Diabetes mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 days 6 weeks	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 14, 1965 , to Dec. 29, 1965 , that (I) (we) last saw the deceased alive on Dec. 29, 1965 , and that death occurred at 3:35 P.M. , from the causes and on the date stated above.			
22a. SIGNATURE V. Juerman		22b. DATE SIGNED 12/29/65	
22c. PHYSICIAN'S NAME (Type) V. Juerman, M.D.		22d. ADDRESS Deer's Head State Hospital; Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1/1/1966	
23c. NAME OF CEMETERY OR CREMATORY ST. ANDREW CEMETERY		23d. LOCATION (City, town or county) (State) PRINCESS ANNE, MD.	
24. FUNERAL DIRECTOR LEVIN R. WILSON		25a. REC'D BY REGISTRAR JAN 4 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Accomac</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Greenbackville</u> d. STREET ADDRESS <u>828 -</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Felter</u> Last <u>MARSHALL</u>		4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>24</u> Year <u>1965</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 31, 1889</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Seafood</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Greenbackville, Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Herbert Marshall</u>		14. MOTHER'S MAIDEN NAME <u>Betty Merrill</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>230-18-0213</u>		17. INFORMANT <u>Garland Marshall, Salisbury Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>330X</u> DUE TO <u>Respiratory Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Subarachnoid Hemorrhage</u> DUE TO (c) <u>2 wks</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Auricular Fibrillation</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 12, 1965</u> to <u>Dec 24, 1965</u> , that (I) (we) last saw the deceased alive on <u>Dec 24, 1965</u> , and that death occurred at <u>8 AM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>David Papat</u>		M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/27/65</u>	
22c. PHYSICIAN'S NAME (Type) <u>DAVID P-P-A-T</u>		22d. ADDRESS <u>Snow Hill Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-27-65</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenbackville</u>	
23d. LOCATION (City, town or county) (State) <u>Worcester County Maryland</u>					
24. FUNERAL DIRECTOR <u>Thomas A. Fleming, Snow Hill, Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 29 1965</u>		25b. REGISTRAR'S SIGNATURE <u>William J. Juge</u>	



1
FOR STATE
HEALTH DEPT.

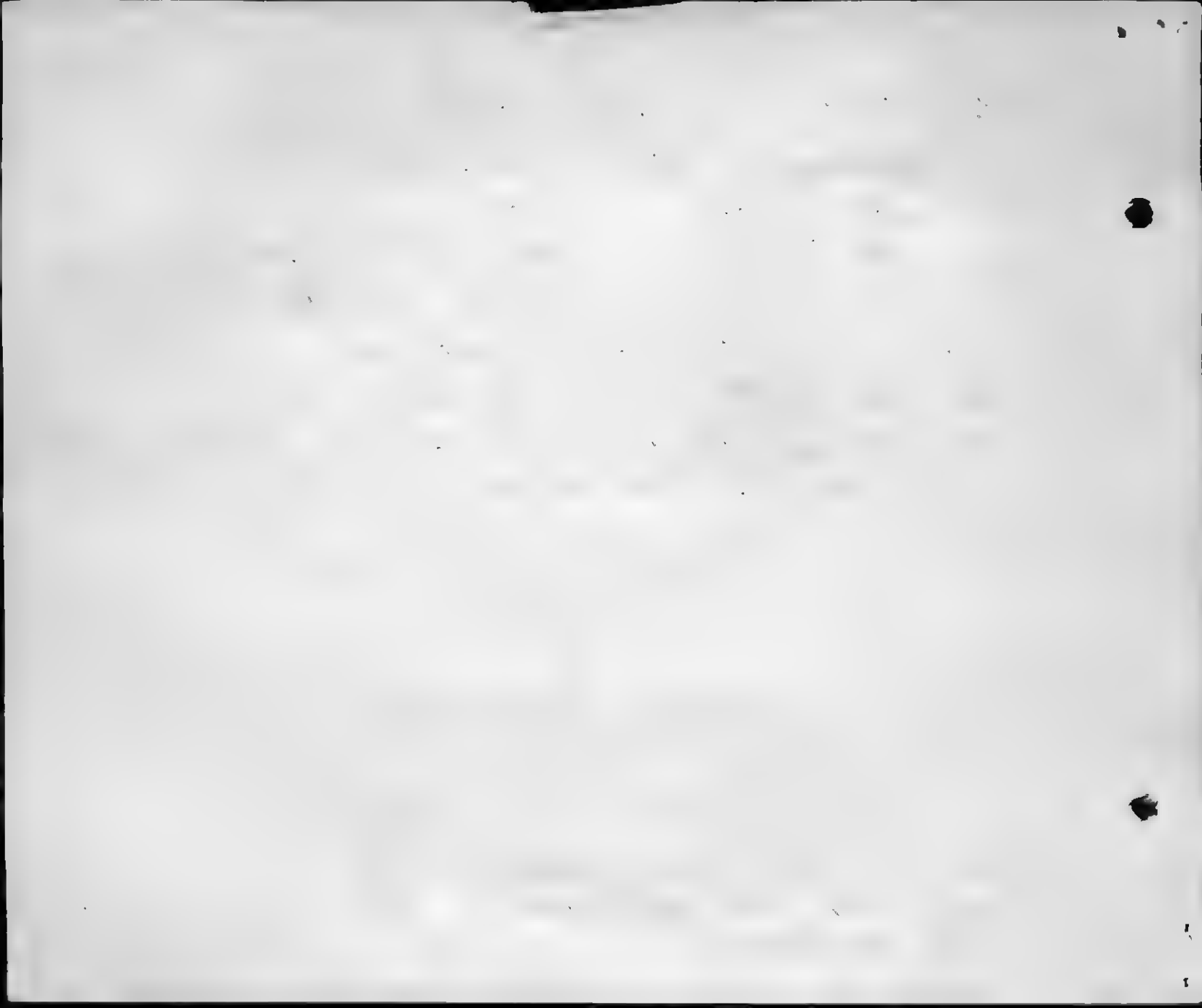
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the local health officer. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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17151

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Whomius</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. COUNTY <u>Whomius</u>	
b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>4 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Gen Sen Hosp</u>		d. STREET ADDRESS <u>Thardella</u>	
3. NAME OF DECEASED (Type or print) <u>Mc Kinley</u>		4. DATE OF DEATH Month <u>December</u> Day <u>27</u> Year <u>1965</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>12-28-1909</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CAMPBELL SOUP, WEST MISS.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FED MC AFAE</u>		14. MOTHER'S MAIDEN NAME <u>HENRETTA KEILY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>UNKNOWN EULAMNE KIMES, MUSKEGON MICH.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac decompensation</u> <u>214</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Faulty plastic heart valve</u> (c), stating the underlying cause last. DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month <u>19</u> Day <u>15</u> Year <u>66</u> Hour <u>5</u> a.m. <u>1</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>mt Glenwood</u>	20f. (City or town) (County) (State) <u>Thornton</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles Judge</u> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>12-28-65</u>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-5-66</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>mt Glenwood</u>		22d. LOCATION (City, town, or country) (State) <u>Thornton</u>	
23. FUNERAL DIRECTOR <u>Brooker M. Lee</u>		24. REC'D BY REGISTRAR <u>J. Charles Judge</u>	
24b. REGISTRAR'S SIGNATURE		DATE <u>JAN 10 1966</u>	



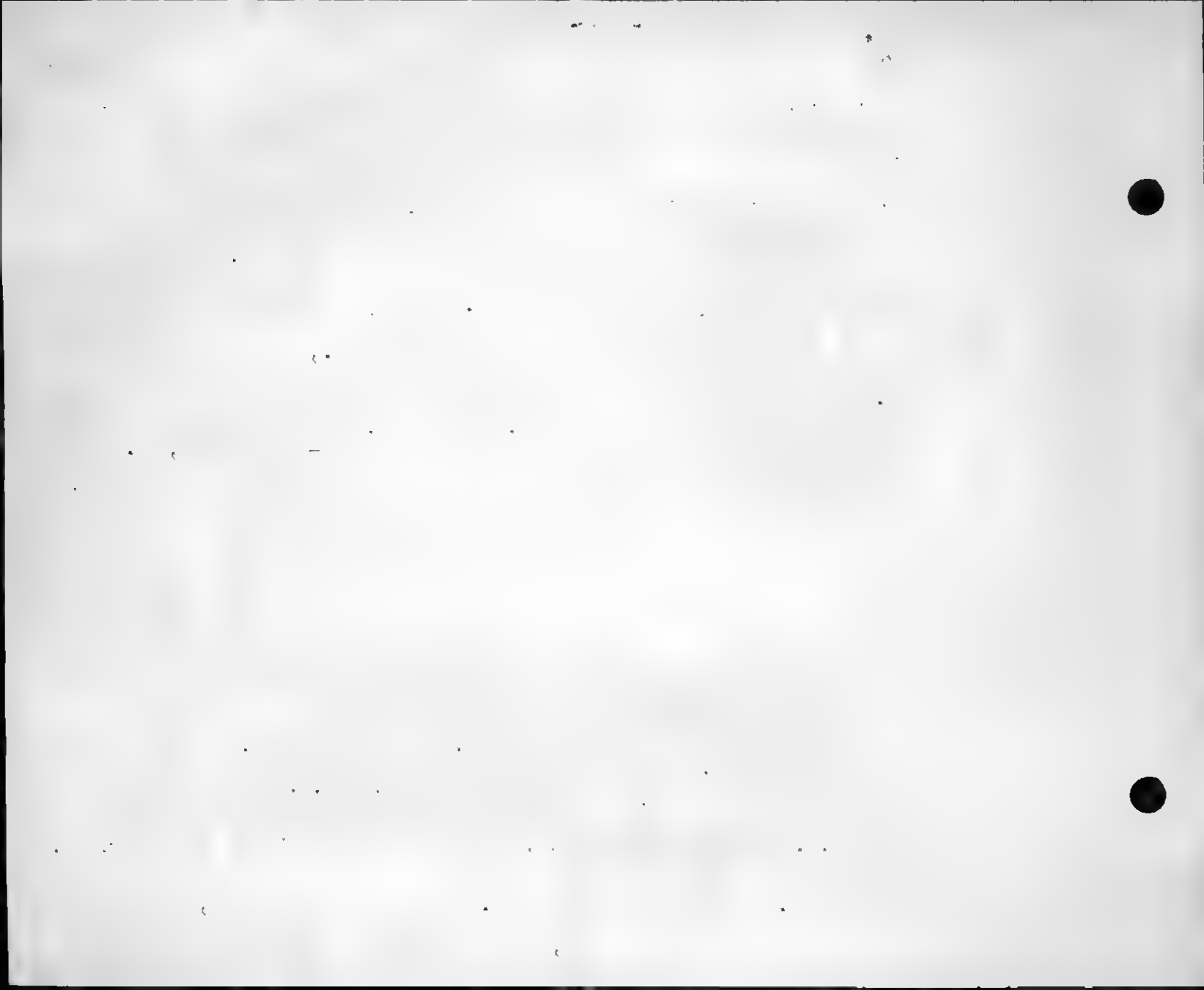
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17152

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 300 E. Vine Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First Lotta Middle Pearl Last McGlothlin		4. DATE OF DEATH Month Dec. Day 8 Year 1965		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 8/1885		9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 9 Days 0 Hours 0 Min. 0		11. IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work at home				10b. KIND OF BUSINESS OR INDUSTRY None				11. BIRTHPLACE (County & State, or foreign country) Somerset Co., Maryland				12. CITIZEN OF WHAT COUNTRY? U S A					
13. FATHER'S NAME Isaac J. Holland				14. MOTHER'S MAIDEN NAME Jennie Barbon				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No									
16. SOCIAL SECURITY NO. Mr. Holland S. Parks (Nephew)				17. INFORMANT Cr. stwood Circle-Salisbury, Md.				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of the cervix - Grade 4 DUE TO (b) 171X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
19. INTERVAL BETWEEN ONSET AND DEATH 1 yr				20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Dec. 7, 1965 , to Dec. 8, 1965 , that (I) (we) last saw the deceased alive on Dec. 8, 1965 , and that death occurred at 12:45 P.M. , from the causes and on the date stated above.																	
22a. SIGNATURE C.F. Gutierrez-Garrido, M.D.				22b. DATE SIGNED 12/8/65				22c. PHYSICIAN'S NAME (Type) C.F. Gutierrez-Garrido, M.D.									
22d. ADDRESS Deer's Head Hospital; Salisbury, Md.																	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Dec. 10/1965				23c. NAME OF CEMETERY OR CREMATORY Wicomico Mem. Park				23d. LOCATION (City, town or county) (State) Salisbury, Maryland					
24. FUNERAL DIRECTOR HOLLWAY & COMPANY				ADDRESS SALISBURY, MARYLAND				25a. REC'D BY REGISTRAR DEC 13 1965				25b. REGISTRAR'S SIGNATURE Charles Judge					

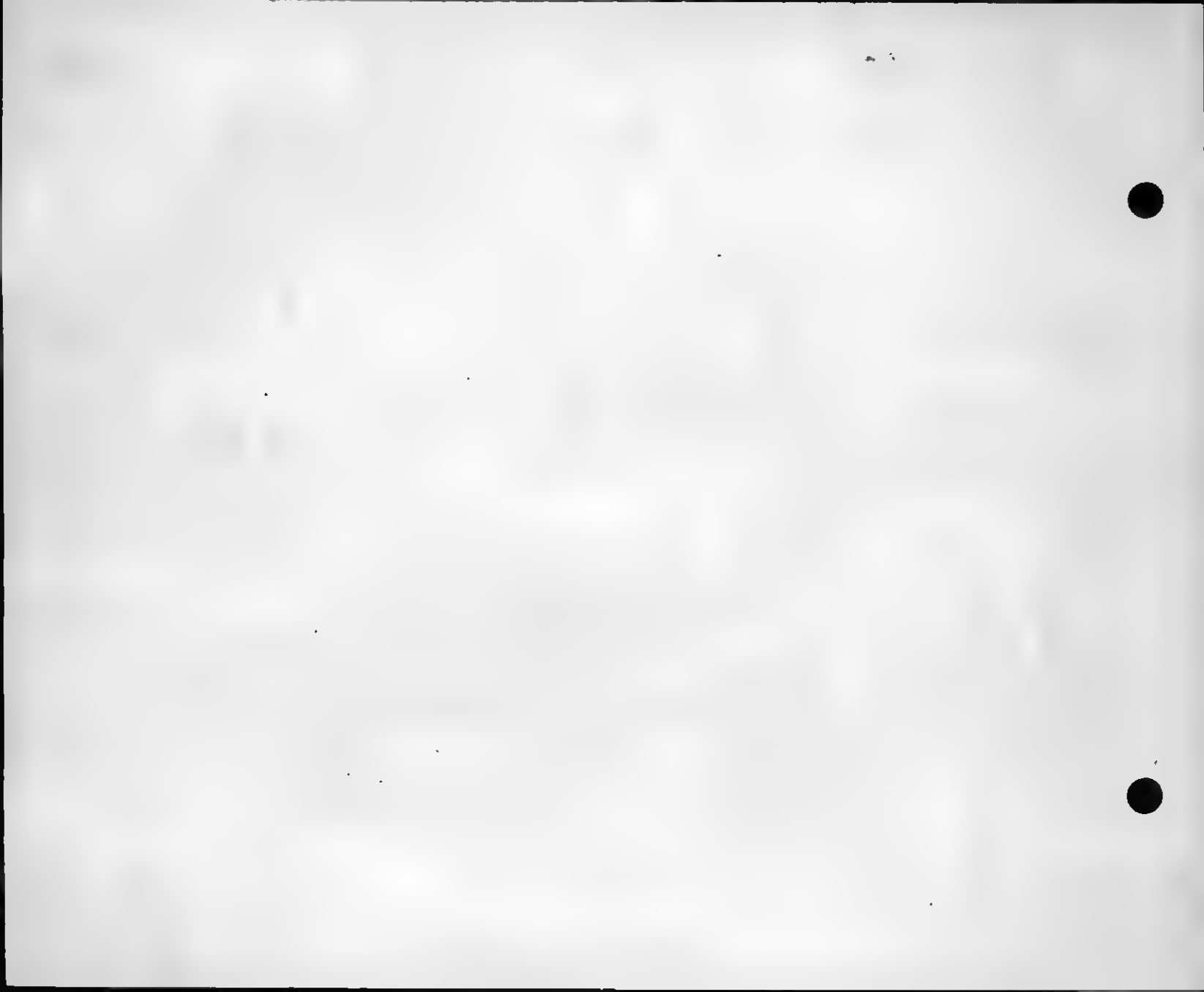


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
17153
CERTIFICATE OF DEATH

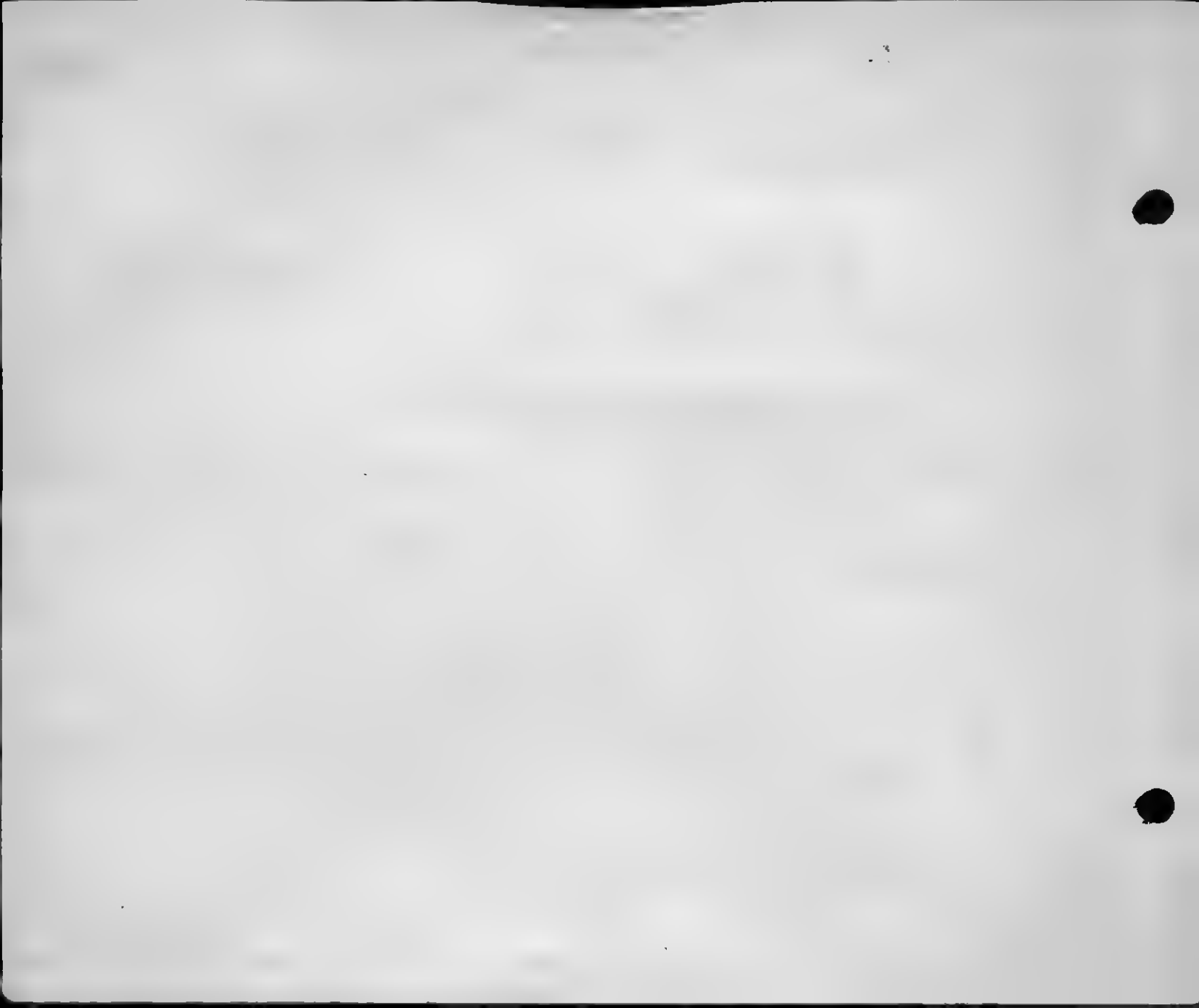
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural-Marbela Springs</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES ANDREW Mc GLOTTEN</u>				4. DATE OF DEATH Month Day Year <u>December 30 1965</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-11-04</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Wm. Mc Ghotter</u>				14. MOTHER'S MAIDEN NAME <u>Murtle - Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>110 219-07-148</u>		17. INFORMANT Address <u>Peninsula Hosp. Wicomico Co. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia and shock</u> DUE TO (b) <u>Pneumonia</u> DUE TO (c) <u>Retained blood in chest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Septicemia and shock</u>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 28.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/12</u> , 19 <u>65</u> , to <u>12/30</u> , 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>12/30</u> , 19 <u>65</u> , and that death occurred at <u>8 P.</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Richard E. Hughes</u>						22b. DATE SIGNED <u>1/3/66</u>	
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>1-2-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. John Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Wicomico Co. Md.</u>	
24. FUNERAL DIRECTOR <u>James B. Washed Carter, Jr.</u>				25a. REC'D BY REGISTRAR <u>AN 6</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
17154 CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>yes</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>106 First St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>John</u> <u>miles</u> First Middle Last					4. DATE OF DEATH <u>12-18-1965</u> Month Day Year				
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1887</u>		9. AGE (In years last birthday) <u>78</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (County & State, or foreign country) <u>NC</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>			
13. FATHER'S NAME <u>unknown</u>					14. MOTHER'S MAIDEN NAME <u>unknown</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>					16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Irma Young</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4221</u> DUE TO <u>Regenerative Heart Disease</u> Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerosis</u> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>Indefinite</u>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 1964</u> to <u>Dec 18, 1965</u> that (I) (we) last saw the deceased alive on <u>Dec 18, 1965</u> and that death occurred at <u>7 PM</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Furnell</u> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>20 Dec 65</u>		
22c. PHYSICIAN'S NAME (Type) <u>E. A. FURNELL</u>					22d. ADDRESS <u>65 E W Main Salisbury Md</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)		
<u>Burial</u>			<u>12-23-65</u>		<u>Glass Hill Cn</u>		<u>Thrsontown Md</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Isabel M Whit</u> ADDRESS					25a. REC'D BY REGISTRAR <u>DEC 27 1965</u> DATE		25b. REGISTRAR'S SIGNATURE <u>W. J. J. J.</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

17155

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN b 407 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg d. STREET ADDRESS 120 Denton Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Clara Middle Moore Last Moore		4. DATE OF DEATH Month December Day 9 Year 1965					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-22-1881	9. AGE (In years last birthday) 84 yrs. IF UNDER 1 YEAR: Months 84 Days 84 Hours 84 Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bottom factory worker		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bottom factory worker		10b. KIND OF BUSINESS OR INDUSTRY Bottom factory		11. BIRTHPLACE (County & State, or foreign country) Sussex Co. Del.	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOHN VOSS		14. MOTHER'S MAIDEN NAME LIDA THOMAS					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-12-4815		17. INFORMANT Mrs. Elva Wooten; Federalsburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Recurrent cerebral thrombosis DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 3 days 3 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 28</u>, 19<u>64</u>, to <u>Dec. 9</u>, 19<u>65</u>, that (I) (we) last saw the deceased alive on <u>Dec. 9</u>, 19<u>65</u>, and that death occurred at <u>2:15 A.M.</u>, from the causes and on the date stated above.							
22a. SIGNATURE L. V. Maldve, M. D.		22b. DATE SIGNED 12/9/65	22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.				
22d. ADDRESS Deer's Head State Hospital; Salisbury, Md.		22e. ADDRESS Deer's Head State Hospital; Salisbury, Md.					
23a. BURIAL, CREMATION, REBURY (Specify)	23b. DATE THEREOF 9-12-65	23c. NAME OF CEMETERY OR CREMATORY Hillcrest	23d. LOCATION (City, town or county)	(State)	(State)		
24. FUNERAL DIRECTOR Harry Williams		25a. REC'D BY REGISTRAR DEC 15 1965	25b. REGISTRAR'S SIGNATURE Charles Judge				

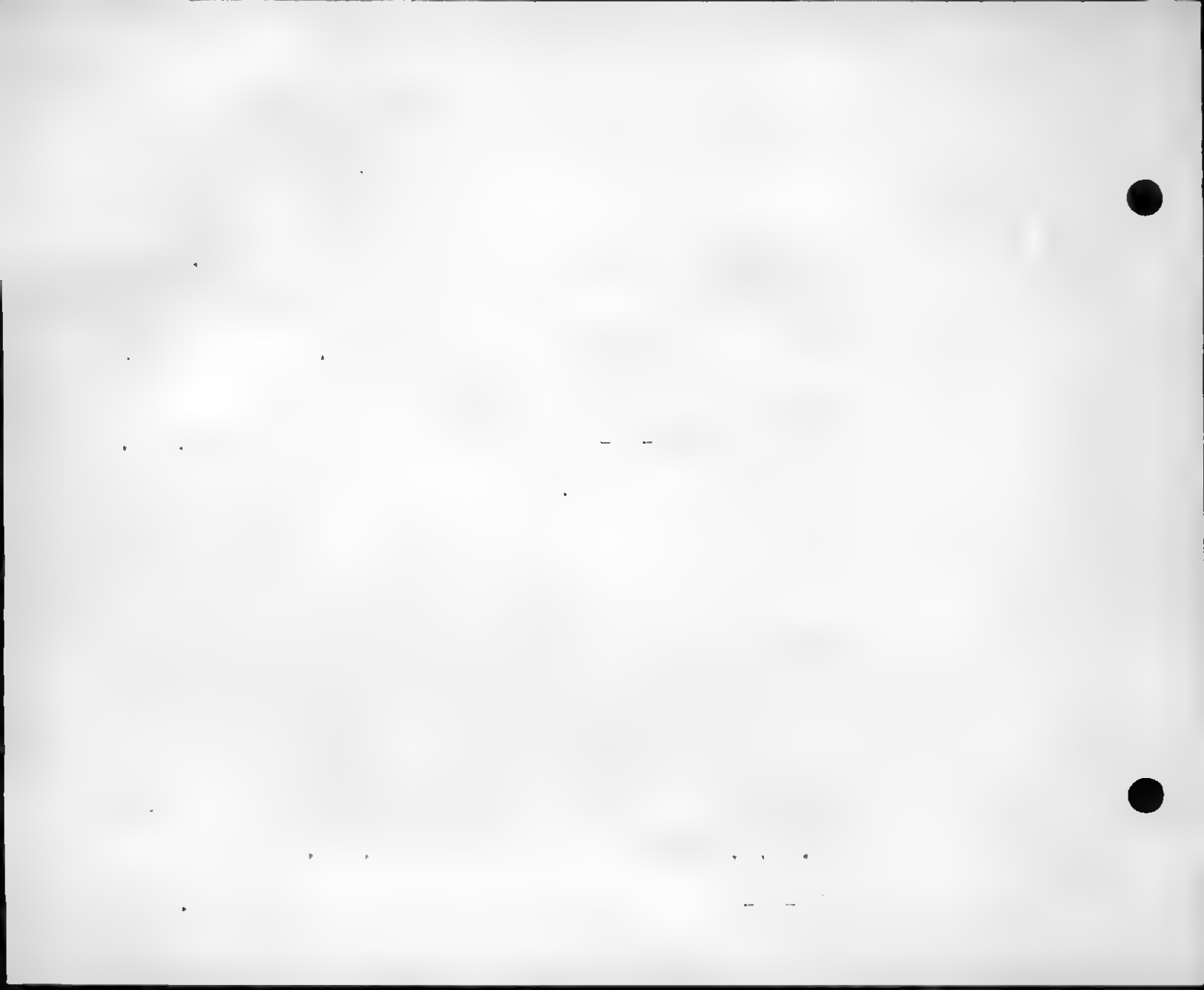


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

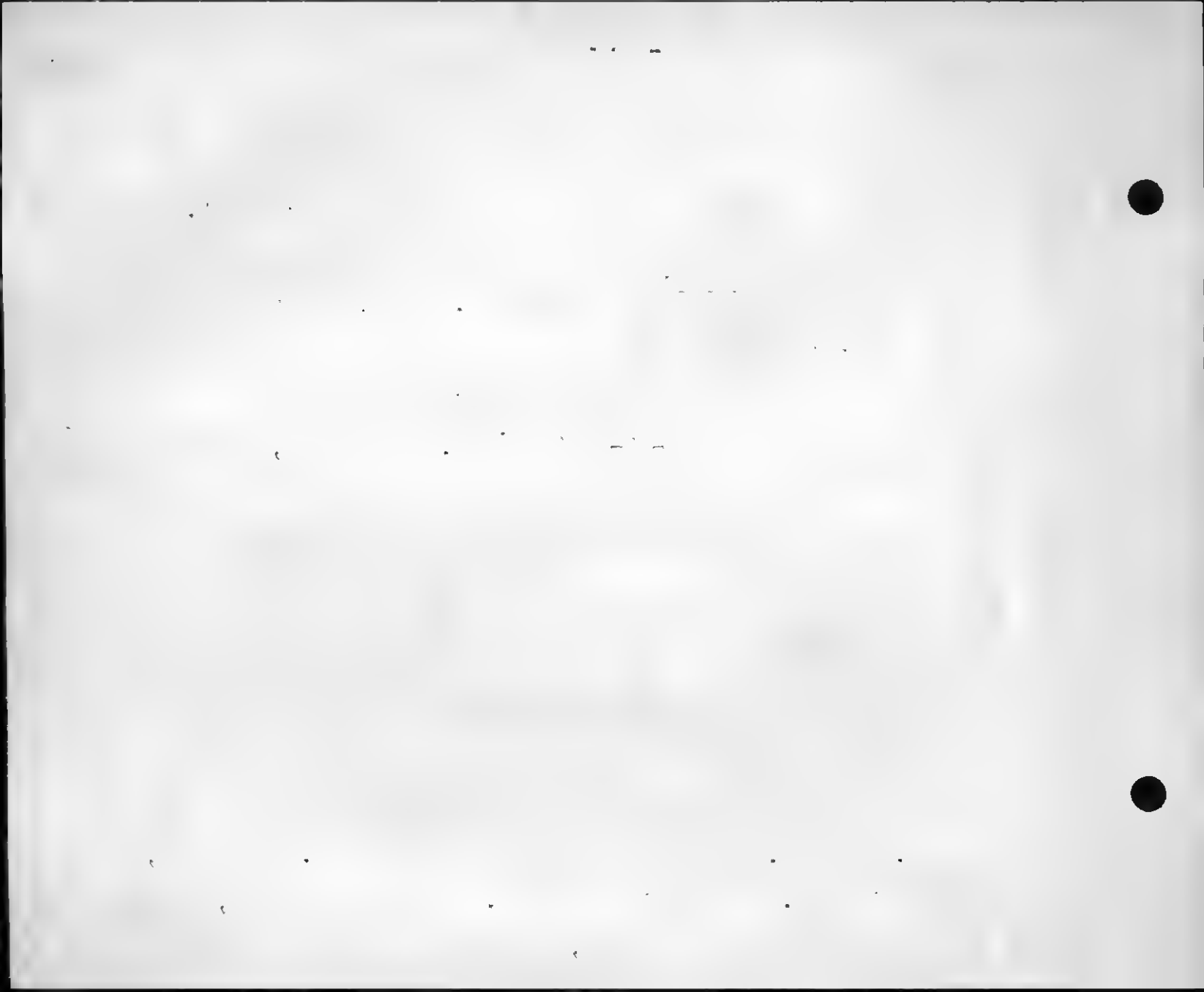
1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 5 yrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt # 2				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS Rt # 2 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First LINWOOD Middle WESLEY Last NUTTER			4. DATE OF DEATH Month Dec. Day 15 Year 19 65									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>								
8. DATE OF BIRTH 5-21-1914		9. AGE (in years last birthday) 51 yrs. <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		
IF UNDER 1 YEAR	IF UNDER 24 HRS.											
Months	Days											
Hours	Min.											
10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (County & State, or foreign country) Oriole, Md.		12. CITIZEN OF WHAT COUNTRY? USA								
13. FATHER'S NAME Caleb Nutter			14. MOTHER'S MAIDEN NAME Edith Muir									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW # 2 214-10-7101		17. INFORMANT Betty Nutter, Salisbury, Md.								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%;"> <tr> <td colspan="2"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial infarct</i> </td> <td rowspan="3"> INTERVAL BETWEEN ONSET AND DEATH <i>5 min</i> <i>5 min</i> <i>5 years</i> </td> </tr> <tr> <td> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. </td> <td> CAUSE TO <i>Coronary artery occlusion</i> </td> </tr> <tr> <td></td> <td> CAUSE TO <i>coronary arteriosclerosis</i> </td> </tr> </table>						PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial infarct</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 min</i> <i>5 min</i> <i>5 years</i>	CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.	CAUSE TO <i>Coronary artery occlusion</i>		CAUSE TO <i>coronary arteriosclerosis</i>
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial infarct</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 min</i> <i>5 min</i> <i>5 years</i>										
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.	CAUSE TO <i>Coronary artery occlusion</i>											
	CAUSE TO <i>coronary arteriosclerosis</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)								
20f. (City or town)		(County)		(State)								
21. I certify that (I) (this hospital) attended the deceased from 1960 , to Dec 15, 19 65 , that (I) (we) last saw the deceased alive on <i>March 30 19 65</i> , and that death occurred at <i>1:30 PM</i> , from the causes and on the date stated above.												
22a. SIGNATURE <i>Dr. L.V. Sohler</i>				22b. DATE SIGNED 12-16-65								
22c. PHYSICIAN'S NAME (Type) Dr. L.V. Sohler				22d. ADDRESS Delmar, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-17-65		23c. NAME OF CEMETERY OR CREMATORY Mardela Memorial								
23d. LOCATION (City, town or county) Mardela, Md.		23e. (State)										
24. FUNERAL DIRECTOR <i>Charles W. Ganel - Delmar, Del.</i>				25a. REC'D BY REGISTRAR DEC 20 1965								
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>												



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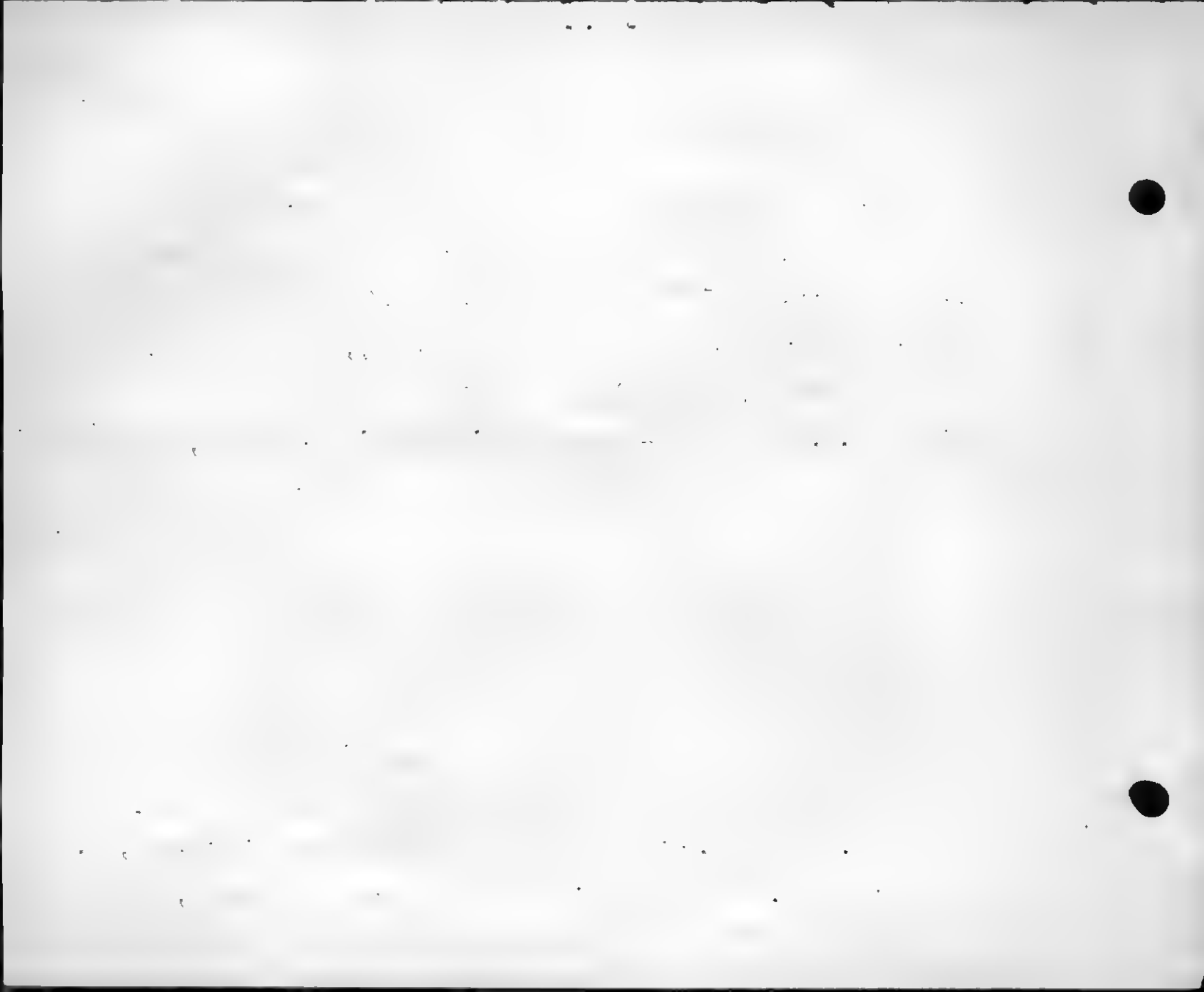
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
17157 CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>						d. STREET ADDRESS <u>825 Fillmore St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Gus</u> Middle <u>(NMI)</u> Last <u>YAPPAS</u>		4. DATE OF DEATH Month <u>December</u> Day <u>28</u> Year <u>1965</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 19/1888</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>3</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook at Restaurant</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Cooking</u>		
11. BIRTHPLACE (County & State, or foreign country) <u>Greece</u>			12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>			13. FATHER'S NAME <u>(Unk)</u>			14. MOTHER'S MAIDEN NAME <u>(Unk)</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>217-10-2170</u>			17. INFORMANT <u>Mr. Chris Chames (Friend)</u> Address <u>307 Carlton Ave. Salisbury, Maryland</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary</u> <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Arterio-Sclerotic Heart Disease</u> DUE TO (c) <u></u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>N/A</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u></u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1953</u> , 19 <u>65</u> , to <u>12/28</u> , 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>12/10</u> , 19 <u>65</u> , and that death occurred at <u>11:20</u> P.M., from the causes and on the date stated above.											
22a. SIGNATURE <u>Dr. Andrew C. Mitchell</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/28/65</u>			
22c. PHYSICIAN'S NAME (Type) <u>Dr. Andrew C. Mitchell</u>						22d. ADDRESS <u>Maryland Ave. Salisbury, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 27/1965</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Mem. Park</u>				23d. LOCATION (City, town or county) (State) <u>Salisbury, Maryland</u>			
24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY</u>						ADDRESS <u>SALISBURY, MARYLAND</u>		25a. REC'D BY REGISTRAR <u>DEC 28 1965</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 12 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 300 Washington St		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 300 Washington St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3. NAME OF DECEASED (Type or print) First RUSSELL Middle EDWARD Last PARKER		4. DATE OF DEATH Month DECEMBER Day 9 Year 1965			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 28/1909		9. AGE (In years last birthday) 56 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 5 Days 11 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Furniture Salesman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Albert Parker (Deceased)				14. MOTHER'S MAIDEN NAME Minnie Riggin					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. W.W.#2 214-10-9224		17. INFORMANT Mrs. Naomi E. Parker (Wife) Address 300 Washington Street Salisbury, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4201 DUE TO (b) Coronary Artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) 5-6 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH Sudden	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) N/A							
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 1960 to 12/9 , 19 65 , that (I) (we) last saw the deceased alive on 12/8 , 19 65 , and that death occurred at ADD M, from the causes and on the date stated above.									
22a. SIGNATURE William D. Gray				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Dec. /1965			
22c. PHYSICIAN'S NAME (Type) Dr. William D. Gray				22d. ADDRESS Camden Avenue Salisbury, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 11/1965		23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION (City, town or county) (State) Salisbury, Maryland			
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY				ADDRESS SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR DEC 13 1965		25b. REGISTRAR'S SIGNATURE Charles Judge	



1
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17159
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>WICOMICO</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SALISBURY</i>		c. LENGTH OF STAY IN 1b <i>MARYLAND</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>General</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Princess Anne</i>		d. STREET ADDRESS <i>R. F. D.</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>MARY</i>		First <i>JANE</i>		Middle <i>POPE</i>		Last <i>POPE</i>		4. DATE OF DEATH Month <i>DECEMBER</i> Day <i>1</i> Year <i>1965</i>		5. SEX <i>FEMALE</i>		6. COLOR OR RACE <i>WHITE</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>7-15-1890</i>		9. AGE (In years last birthday) <i>75</i> yrs.		10. IF UNDER 1 YEAR Months <i>7</i> Days <i>15</i> Hours <i>15</i> Min.		11. BIRTHPLACE (County & State, or foreign country) <i>Princess Anne Co. MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>	
10b. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME <i>Edward Mills</i>		14. MOTHER'S MAIDEN NAME <i>Mary Braddell</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Eddie Mulchay</i>		Address <i>Princess Anne</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> <i>260X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Diabetes mellitus</i> DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Bilateral A.H. Amputation</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs</i>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <i>9:45</i> M, from the causes and on the date stated above.		22a. SIGNATURE <i>Lewis R. Wilson</i>		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <i>Lewis R. Wilson</i>	
22d. ADDRESS <i>Princess Anne</i>		22e. M.O. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS <i>Princess Anne</i>		23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		23b. DATE THEREOF <i>12/4/65</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Andrew</i>		23d. LOCATION (City, town or county) (State) <i>Princess Anne MD</i>	
24. FUNERAL DIRECTOR <i>Lewis R. Wilson</i>		24a. REC'D BY REGISTRAR <i>DEC 7 1965</i>		24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		24c. ADDRESS <i>Princess Anne</i>		24d. DATE <i>DEC 7 1965</i>		24e. SIGNATURE <i>Charles Judge</i>		24f. ADDRESS <i>Princess Anne</i>	

1944

1945

1946

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
17160 CERTIFICATE OF DEATH 42									
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 SALISBURY</u> d. STREET ADDRESS <u>207 TRUITT</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>George</u>		First <u>Thomas</u>		Middle <u>Poulson</u>		Last		4. DATE OF DEATH Month <u>December</u> Day <u>19</u> Year <u>1965</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-15-1887</u>		9. AGE (In years last birthday) <u>78</u> yrs. IF UNDER 1 YEAR: Months <u>7</u> Days <u>15</u> Hours <u>15</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RT. ENGINEER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>		11. BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ERASMUS POULSON</u>					14. MOTHER'S MAIDEN NAME <u>ELLEN EAST</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>716-03-1686</u>		17. INFORMANT <u>Elia Poulson-Salisbury, Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>12-12, 1965</u> to <u>12-19, 1965</u> , that (I) (we) last saw the deceased alive on <u>12-19, 1965</u> , and that death occurred at <u>6:00</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>William R. Edles</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12-19-65</u>	
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12-22-65</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. STEPHENS</u>			23d. LOCATION (City, town or county) <u>DELMAR-DEL</u> (State) _____		
24. FUNERAL DIRECTOR <u>Charles W. Marvel - Delmar, Md.</u>						25a. REC'D BY REGISTRAR <u>DEC 22 1965</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

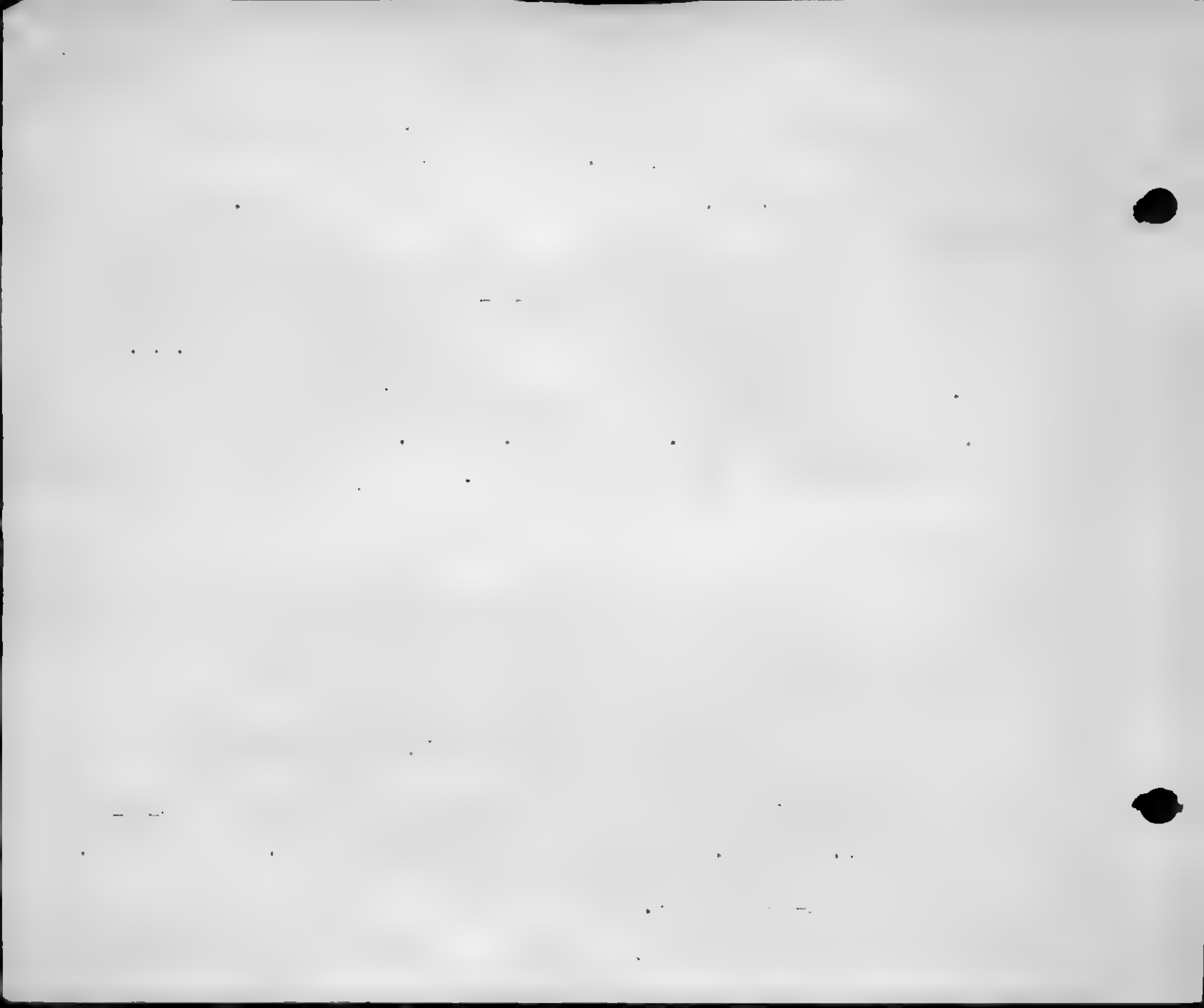
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

17161

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN lb <u>3 Yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>301 Woodcrest Ave.,</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>301 Woodcrest Ave.,</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>BEULAH</u> <u>ESTELLE</u> <u>POWELL</u>		4. DATE OF DEATH Month <u>12</u> Day <u>18</u> Year <u>1965</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>6-25-1892</u> 9. AGE (In years last birthday) <u>73</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Postmaster</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>E. Murray Bethard</u>			14. MOTHER'S MAIDEN NAME <u>Rowena Brittingham</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>No.</u>		17. INFORMANT <u>Mrs. Allen H. Crowley, Same</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Cardiovascular</u> DUE TO <u>disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY Month, Day, Year _____ Hour a.m. _____ p.m. _____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that (I) (this hospital) attended the deceased from <u>9/28/63</u> 19 <u>63</u> to <u>12/18/65</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>12/17/65</u> 19 <u>65</u> , and that death occurred at <u>12/18/65</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Dr. Andrew C. Mitchell</u> 22c. PHYSICIAN'S NAME (Type) <u>Dr. Andrew C. Mitchell</u>				22b. DATE SIGNED <u>12-20-1965</u> 22d. ADDRESS <u>211 Maryland Ave., Salisbury, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-21-1965</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hill Funeral Home</u> <u>Salisbury, Maryland</u>				25a. REC'D BY REGISTRAR <u>DEC 27 1965</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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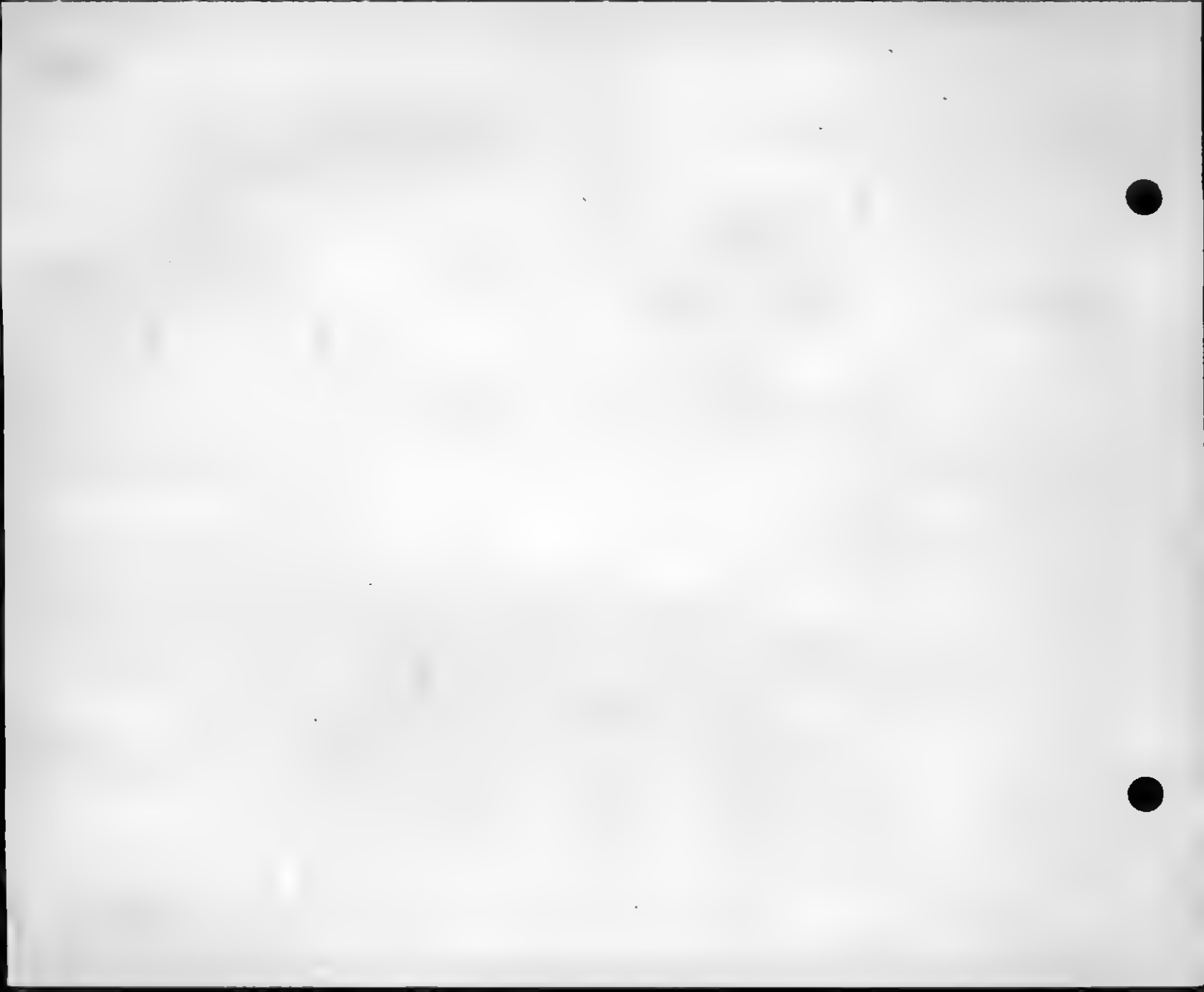
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17162

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PENNSULA GENERAL HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wic.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury Md.</u> d. STREET ADDRESS <u>115 Catherine St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>James W.</u>		4. DATE OF DEATH <u>PRICE</u> Month <u>DECEMBER</u> Day <u>24</u> Year <u>1965</u>					
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Aug 19-70</u>				
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		9b. KIND OF BUSINESS OR INDUSTRY					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (County & State, or foreign country) <u>Wicomico -</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>					
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>W.W. II</u>		16. SOCIAL SECURITY NO. <u>W.W. II</u>					
17. INFORMANT <u>Cleo Drorton</u>		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage From Bowel</u> 157X DUE TO (b) <u>Carcinomatous</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Carcinoma of Ovary</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 Hrs</u> <u>4 months</u> <u>App 1 yr</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>9/12</u> , 19 <u>65</u> , to <u>12/24</u> , 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>12/24</u> , 19 <u>65</u> , and that death occurred at <u>2A</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>John M. Bloxom Jr</u>		22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <u>JOHN M. BLOXOM JR</u>		22d. ADDRESS <u>MEDICAL CENTER, SALISBUARY MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF					
23c. NAME OF CEMETERY OR CREMATORY <u>Green Acres</u>		23d. LOCATION (City, town or county) (State) <u>Salisbury Md</u>					
24. FUNERAL DIRECTOR <u>Booker McEwen</u>		25a. REC'D BY REGISTRAR <u>DEC 28 1965</u>					
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

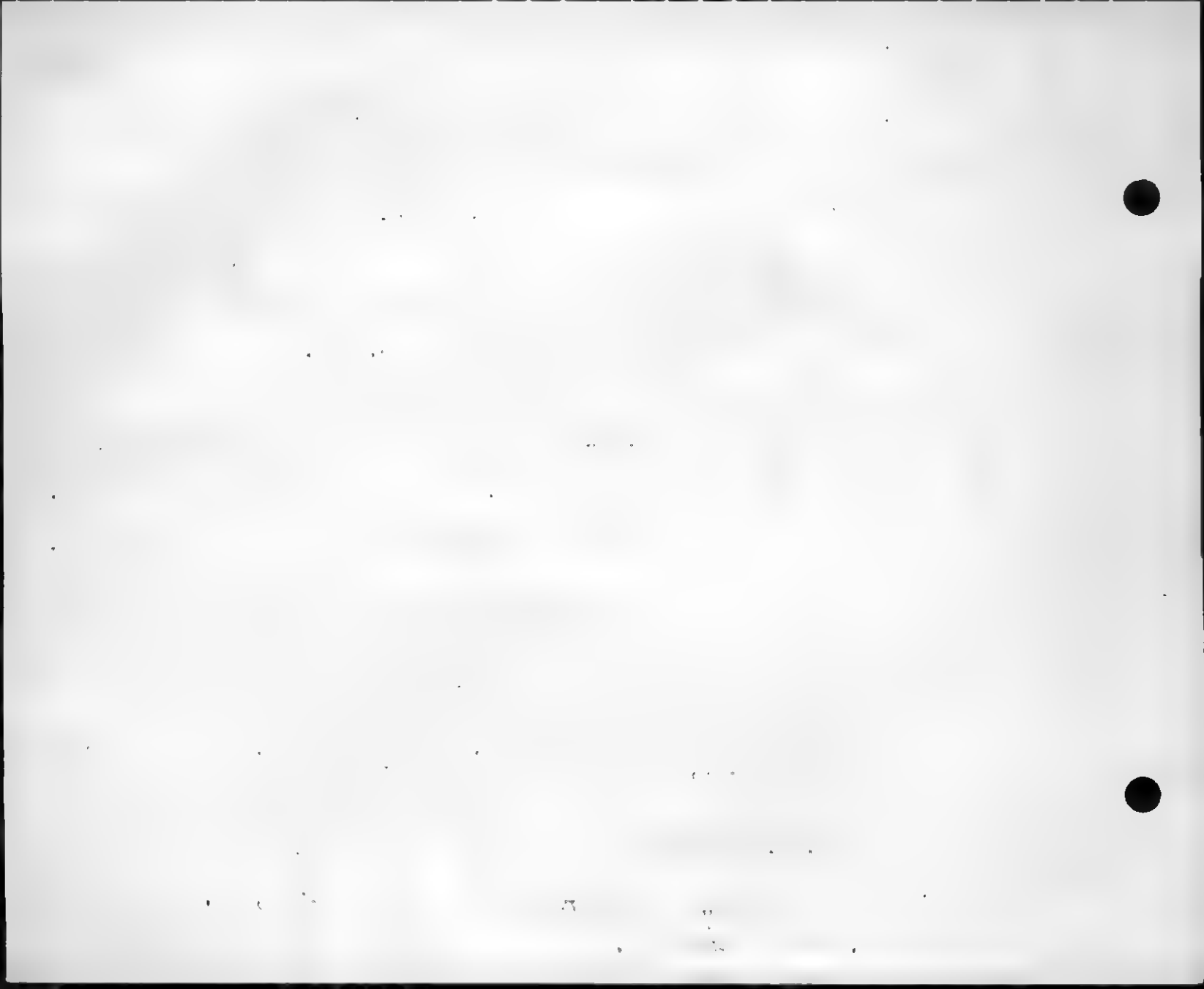


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<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>									
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b Since 1/16/63 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pine Bluff State Hospital					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton d. STREET ADDRESS 210 Goldsborough Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First John Middle Henry Last Price			4. DATE OF DEATH Month December Day 7 Year 19 65						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/28/1903		9. AGE (In years last birthday) 61 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Talbot Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Price					14. MOTHER'S MAIDEN NAME Zenia Parrott				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)			16. SOCIAL SECURITY NO. 217-05-9864		17. INFORMANT Records of Pine Bluff State Hospital Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Emphysema CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (b) Pulmonary Tuberculosis (c)									INTERVAL BETWEEN ONSET AND DEATH 7 yrs. 15 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Jan. 16 , 1963, to Dec. 7 , 1965, that we last saw the deceased alive on Dec. 7 , 1965, and that death occurred at 7:30 P , from the causes and on the date stated above.									
22a. SIGNATURE <i>E. P. Ritchings</i>								22b. DATE SIGNED 12/7/65	
22c. PHYSICIAN'S NAME (Type) E. P. Ritchings					22d. ADDRESS Salisbury, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/10/1965		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Memorial Park		23d. LOCATION (City, town or county) (State) Easton, Md.			
24. FUNERAL DIRECTOR MAURICE E. NEWMAN & SON Easton, Md.					25a. REC'D BY REGISTRAR DEC 10 1965		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

MEDICAL CERTIFICATION



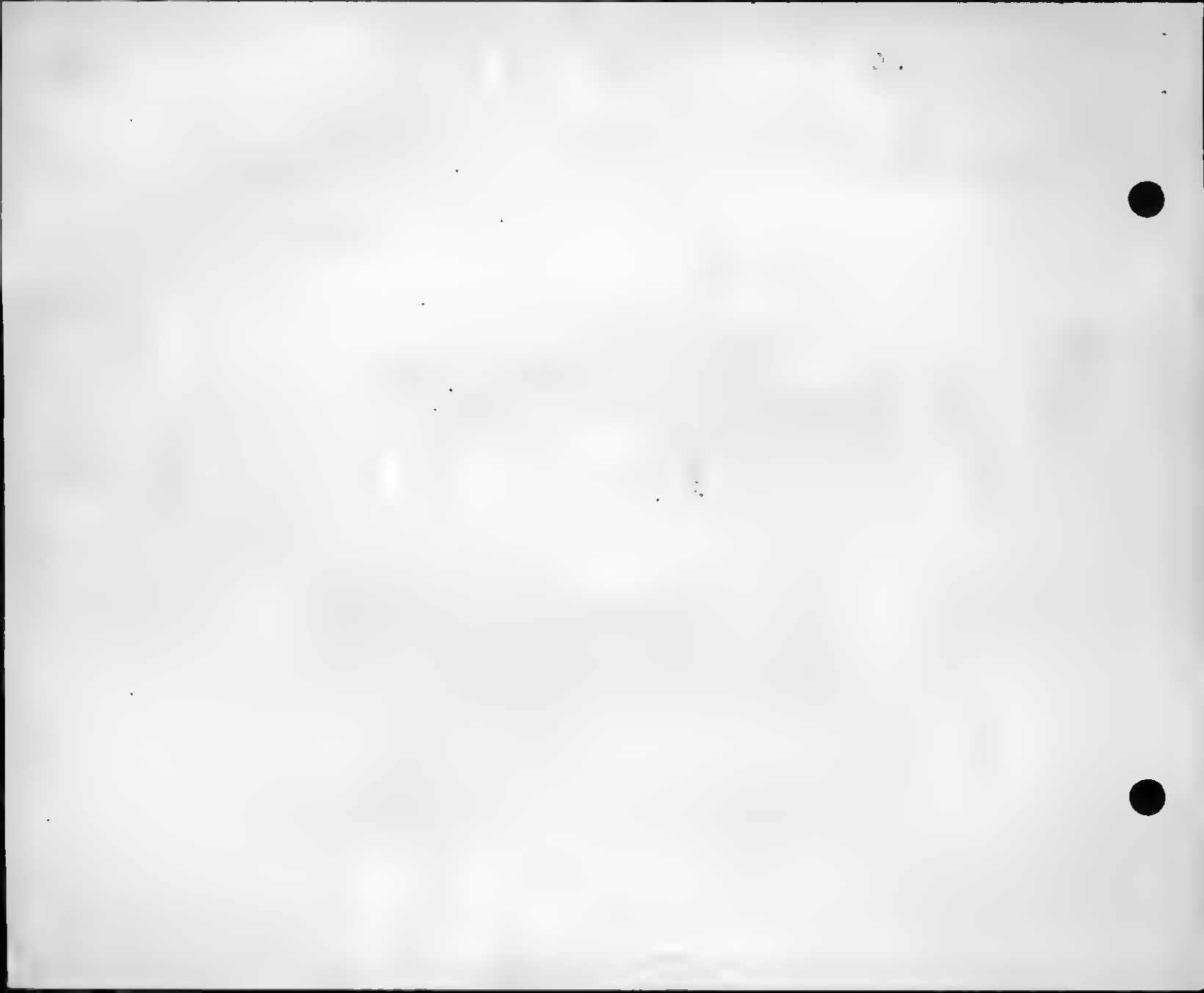
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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
17164 CERTIFICATE OF DEATH 10648									
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Snow Hill 23x2</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <u>Baby Boy Purnell</u>			4. DATE OF DEATH Month Day Year <u>December 10 1965</u>		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. yrs. Months Days Hours Min. <u>5 20</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 14, 1965</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Worcester Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Willie Waters</u>			14. MOTHER'S MAIDEN NAME <u>Gladys Purnell</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)			
16. SOCIAL SECURITY NO. <u>None</u>			17. INFORMANT <u>Willie Waters, Snow Hill, Md.</u> Address						
18. CAUSE OF DEATH [Enter only one cause for line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X Prematurity #203</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>6 P</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>W. C. Morgan</u>					22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)		
22d. ADDRESS					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
<u>Burial</u>		<u>12-12-65</u>		<u>Coolsprings Cemetery</u>		<u>Girdletraw Md</u>			
24. FUNERAL DIRECTOR <u>James F. Harris, Snow Hill, Md</u>					25a. REC'D BY REGISTRAR DATE <u>DEC 14 1965</u>		25b. REGISTRAR'S SIGNATURE <u>Johnas Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

17165

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b <u>1 yr</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marbleton Md</u> d. STREET ADDRESS <u>Georgetown Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARGARET</u> First Middle Last 4. DATE OF DEATH <u>ROSE</u> Month <u>DECEMBER</u> Day <u>14</u> Year <u>1965</u>		5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>NEGRO</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>9-4-08</u> 9. AGE (In years last birthday) <u>62</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Wicomico Co</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>unknown</u> 14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) <u> </u> 16. SOCIAL SECURITY NO. <u>222-05-325</u> 17. INFORMANT <u>Anne Childs</u> Address <u> </u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u> </u> p.m. <u> </u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) (County) (State) <u> </u>		21. I certify that (I) (this hospital) attended the deceased from <u>12-18</u> , 19 <u>65</u> to <u>12-14</u> , 19 <u>65</u> that (I) (we) last saw the deceased alive on <u>12-14</u> , 19 <u>65</u> , and that death occurred at <u>24</u> M, from the causes and on the date stated above. 22a. SIGNATURE <u>William R. Elders Jr</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>12-14-65</u> 22c. PHYSICIAN'S NAME (Type) <u> </u> 22d. ADDRESS <u> </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>12-18-65</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Georgetown Cem</u> 23d. LOCATION (City, town or county) (State) <u>Georgetown Md.</u>		24. FUNERAL DIRECTOR <u>Brooks m west</u> ADDRESS <u> </u> 25a. REC'D BY REGISTRAR <u>DEC 20 1965</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

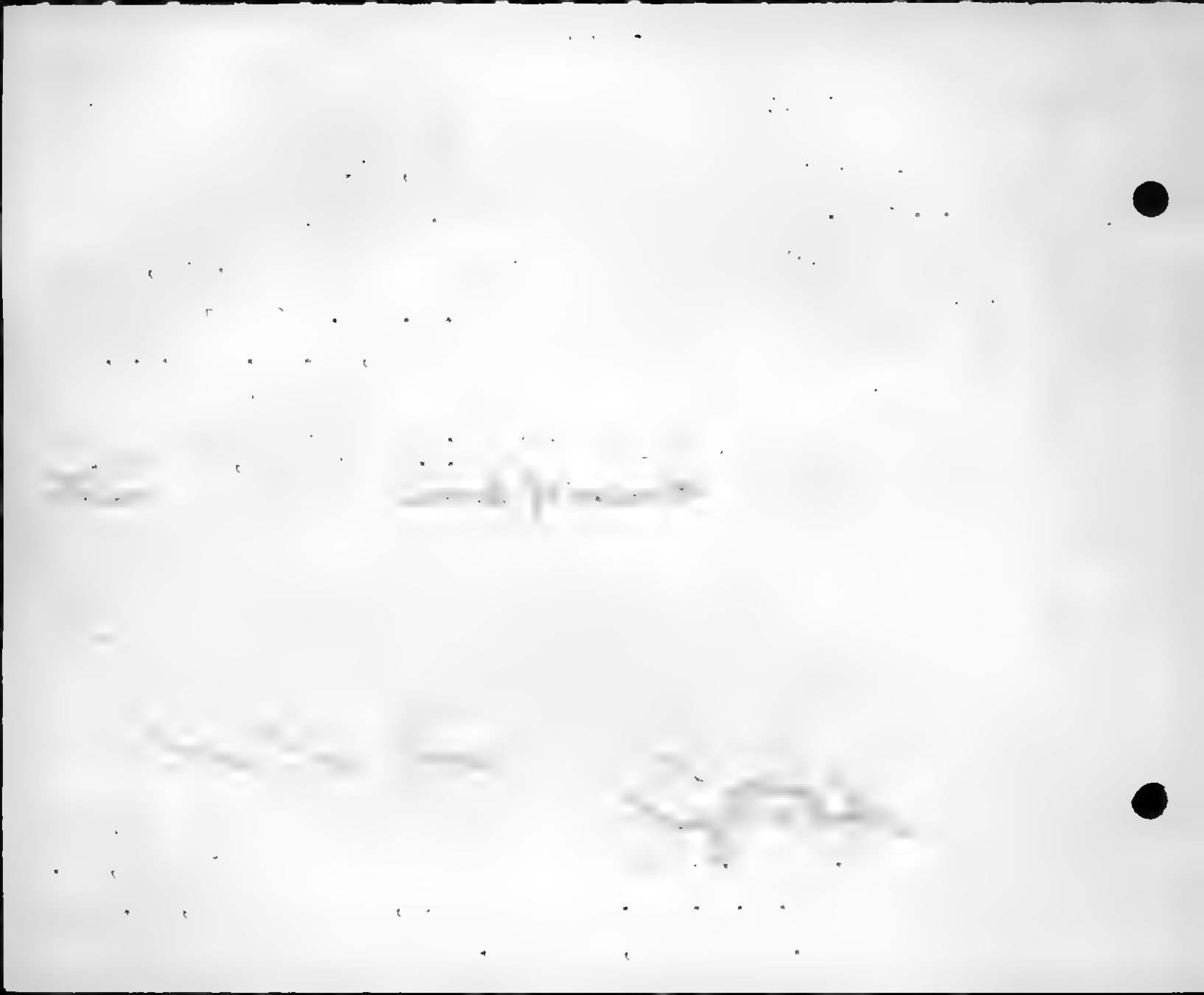
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
17166
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Maryland</u> c. LENGTH OF STAY IN 1b <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Willards</u> d. STREET ADDRESS <u>Rural</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Helen</u> First <u>Shockley</u> Middle Last 4. DATE OF DEATH <u>December 4</u> 19 <u>65</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>July 13, 1912</u> 9. AGE (in years last birthday) <u>53</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Medical Nurse</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <u>Wicomico Co. Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William H. Shockley</u> 14. MOTHER'S MAIDEN NAME <u>Wm Annie Towns</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes give war or dates of service) <u>—</u> 16. SOCIAL SECURITY NO. <u>214-348-8003</u> 17. INFORMANT <u>Ralph Shockley</u> Address <u>Willards, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Failure</u> 2041 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myelogenous Leukemia</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Nov 28, 1965</u> to <u>Dec 4, 1965</u> , that (I) <u>was</u> last saw the deceased alive on <u>Dec 4, 1965</u> , and that death occurred at <u>8:15 PM</u> , from the causes and on the date stated above.	
22a. SIGNATURE <u>Thomas C. Hill Jr.</u> M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>THOMAS C. HILL JR.</u> 22d. ADDRESS <u>Pine Bluff Road, Salisbury, Md.</u>		22b. DATE SIGNED <u>Dec 4, 1965</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Dec 7, 1965</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Mitchell</u> 23d. LOCATION (City, town, or county) (State) <u>Willards Md.</u>		24. FUNERAL DIRECTOR <u>Henry N. Watson</u> ADDRESS <u>Pocomoke City, Md.</u> 25a. REC'D BY REGISTRAR <u>DEC 7 1965</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

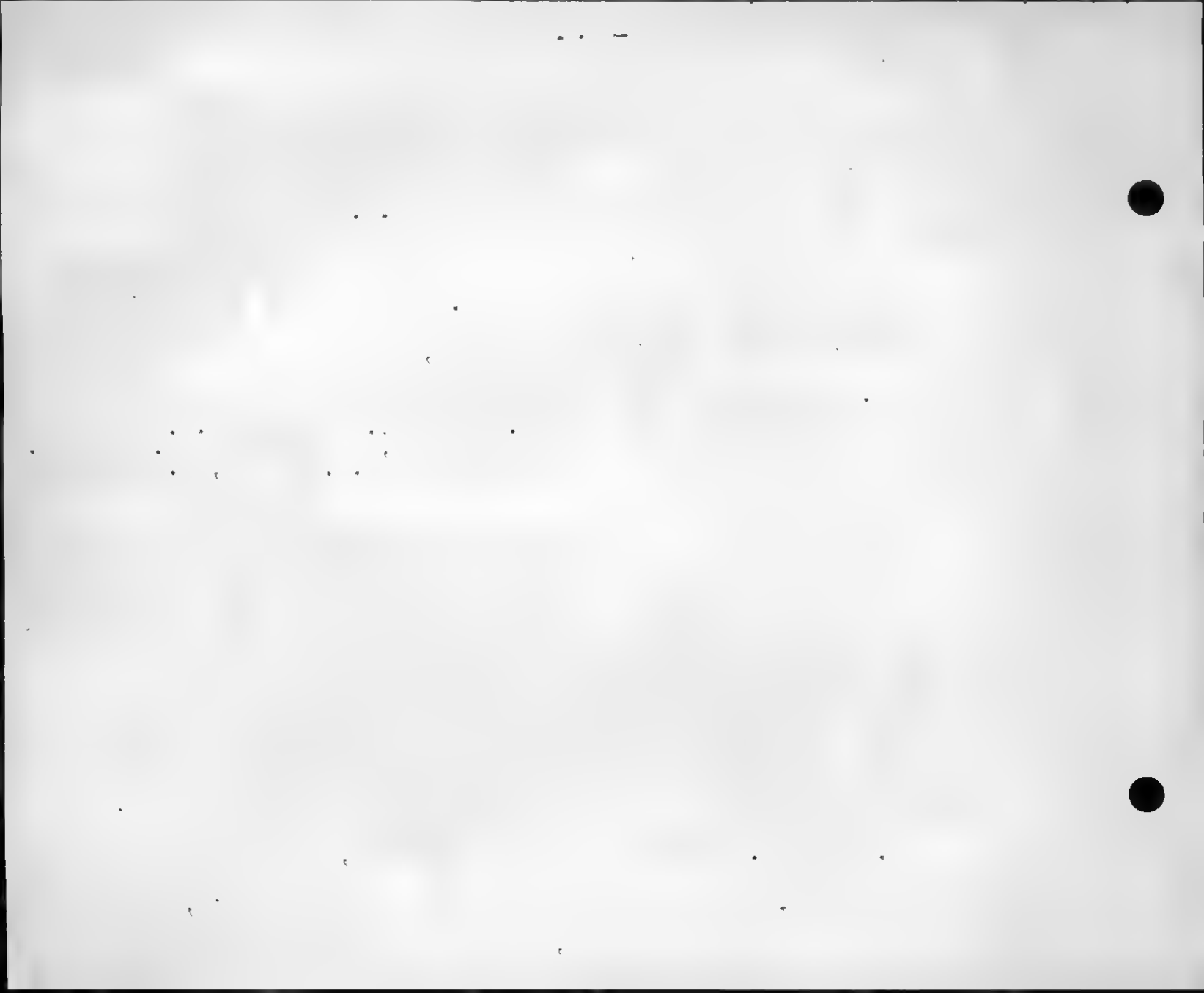
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please (stamp) carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>												2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eden</u> d. STREET ADDRESS <u>R.D.# 2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Perry Preston Smith</u>						4. DATE OF DEATH <u>December 22 1965</u>						5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>											
8. DATE OF BIRTH <u>Sept. 21/1886</u>						9. AGE (in years last birthday) <u>79</u> yrs. IF UNDER 1 YEAR: Months <u>3</u> Days <u>1</u> Hours <u>Min.</u>						10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer Retired</u>											
10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>						11. BIRTHPLACE (County & State, or foreign country) <u>Eden, Maryland</u>						12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>											
13. FATHER'S NAME <u>Thomas J. Smith</u>												14. MOTHER'S MAIDEN NAME <u>Julia Jones</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>												16. SOCIAL SECURITY NO. <u>INFORMANT</u>											
17. INFORMANT <u>Mr. Preston T. Smith (Son) R.D.#1</u>												Address <u>Parsonsburg, Maryland & Mrs. Sissie P. Smith (wife) R.D.#2 Eden, Md.</u>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>arteriosclerosis, generalized</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH <u>10 months</u> years											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>						20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)						20g. (City or town) (County) (State)						20h. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> , 19 <u>59</u> , to <u>Dec 22</u> , 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>Dec 22</u> , 19 <u>65</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.																							
22a. SIGNATURE <u>Robert T. Adkins</u>												22b. DATE SIGNED <u>22 Dec 65</u>											
22c. PHYSICIAN'S NAME (Type) <u>Dr. Robert T. Adkins</u>												22d. ADDRESS <u>Fruitland, Maryland</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						23b. DATE THEREOF <u>Dec. 24/1965</u>						23c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>											
23d. LOCATION (City, town or county) (State) <u>Salisbury, Maryland</u>						23e. REC'D BY REGISTRAR <u>Charles Judge</u>						23f. REGISTRAR'S SIGNATURE											
24. FUNERAL DIRECTOR <u>HOLIOWAY & COMPANY</u>												24a. ADDRESS <u>SALISBURY, MARYLAND</u>											
24b. DATE <u>DEC 28 1965</u>												24c. REGISTRAR'S SIGNATURE											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17169

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> d. STREET ADDRESS <u>228-2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Holland</u>		First <u>Holland</u>		Middle <u>Stanford</u>		Last <u>Stanford</u>		4. DATE OF DEATH <u>December 3</u> 19 <u>65</u> Month <u>December</u> Day <u>3</u> Year <u>1965</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>June 3 1913</u>		9. AGE (In years last birthday) <u>52</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Amusement Machines</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Snow Hill, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm David Stanford</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Payne</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>215-20-0479</u>		17. INFORMANT <u>Elva S. Dryden, Snow Hill, Maryland</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Cerebral Myocardial Infarct</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u> (c) <u>Heart Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>Yes</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 29, 1965</u> to <u>Dec 3, 1965</u> , that (I) (we) last saw the deceased alive on <u>Dec 3, 1965</u> , and that death occurred at <u>4:30</u> P.M. from the causes and on the date stated above.									
22a. SIGNATURE <u>David Rafat</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>DAVID RAFAT</u>				22d. ADDRESS <u>Snow Hill Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-6-65</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Whitcomb Methodist</u>		23d. LOCATION (City, town or county) (State) <u>Snow Hill Maryland</u>			
24. FUNERAL DIRECTOR <u>Erman F. Harris</u>				ADDRESS <u>Snow Hill, Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 7 1965</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in all even if within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN ID 2 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS Route # 1	
3. NAME OF DECEASED (Type or print) Groverman Travis Sterling			4. DATE OF DEATH 12-4-65		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-15-86	9. AGE (in years last birthday) 79 yrs.	IF UNDER 1 YEAR: Months Days Hours Min. 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood		11. BIRTHPLACE (State or foreign country) Crisfield, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Noah T. Sterling			
14. MOTHER'S MAIDEN NAME Mary Elizabeth Tyler		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			
16. SOCIAL SECURITY NO. 218-16-5008		17. INFORMANT Percy G. Sterling, Salisbury, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4222 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Coronary Heart Failure DUE TO (c) Myocardial Degeneration		INTERVAL BETWEEN ONSET AND DEATH hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Earl L. Royer, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 12-6-65	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) 109 Camden Ave., Salisbury, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/7/65		23c. NAME OF CEMETERY OR CREMATORY Sunnyridge Cemetery	
23d. LOCATION (City, town or county) Crisfield, Maryland		23e. (State) Maryland			
24. FUNERAL DIRECTOR Bradshaw & Sons, Crisfield, Maryland		ADDRESS		25a. REC'D BY REGISTRAR DEC 10 1965	
25b. REGISTRAR'S SIGNATURE J. Charles Judge					

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Handwritten text, possibly a signature or date, located in the lower right quadrant.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the final certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.

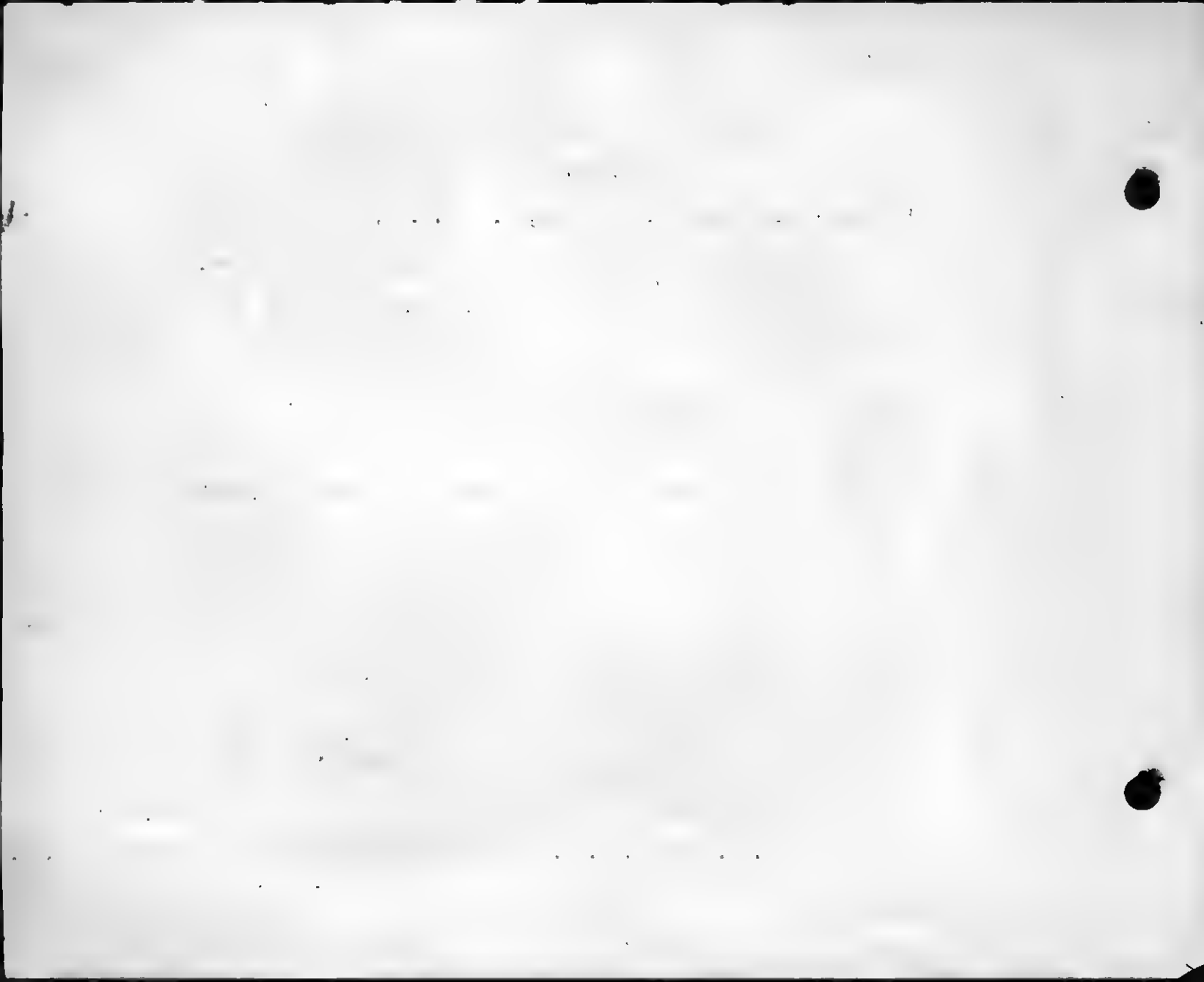
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

17171

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN ID 43 Days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Talbot	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Deer's Head State Hospital, Salisbury, Md.				e. STREET ADDRESS R.D. 2, Box 27				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lillian		First		Middle		Last		4. DATE OF DEATH Month Day Year Dec. 28 19 65	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 1 - 1896		9. AGE (in years last birthday) 69 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) GRASONVILLE MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE WASHINGTON MILLER				14. MOTHER'S MAIDEN NAME MARY ROSETTA EVANS					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT W.R. SUTHERLAND - EASTON MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inter-capillary glomerulosclerosis, diabetic X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/15, 1965 to 12/28, 19 65 that (I) (we) last saw the deceased alive on 12/28 19 65 , and that death occurred at 2:20 P.M. from the causes and on the date stated above.									
22a. SIGNATURE L. V. Maldve						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 12/28/65	
22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.						22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF Dec. 30		23c. NAME OF CEMETERY OR CREMATORY WOODLAWN		23d. LOCATION (City, town or county) (State) EASTON MARYLAND			
24. FUNERAL DIRECTOR Edgar L. Lane Church Hill, Ind.						25a. REC'D BY REGISTRAR JAN 4 1966		25b. REGISTRAR'S SIGNATURE J. H. - [Signature]	

MEDICAL CERTIFICATION

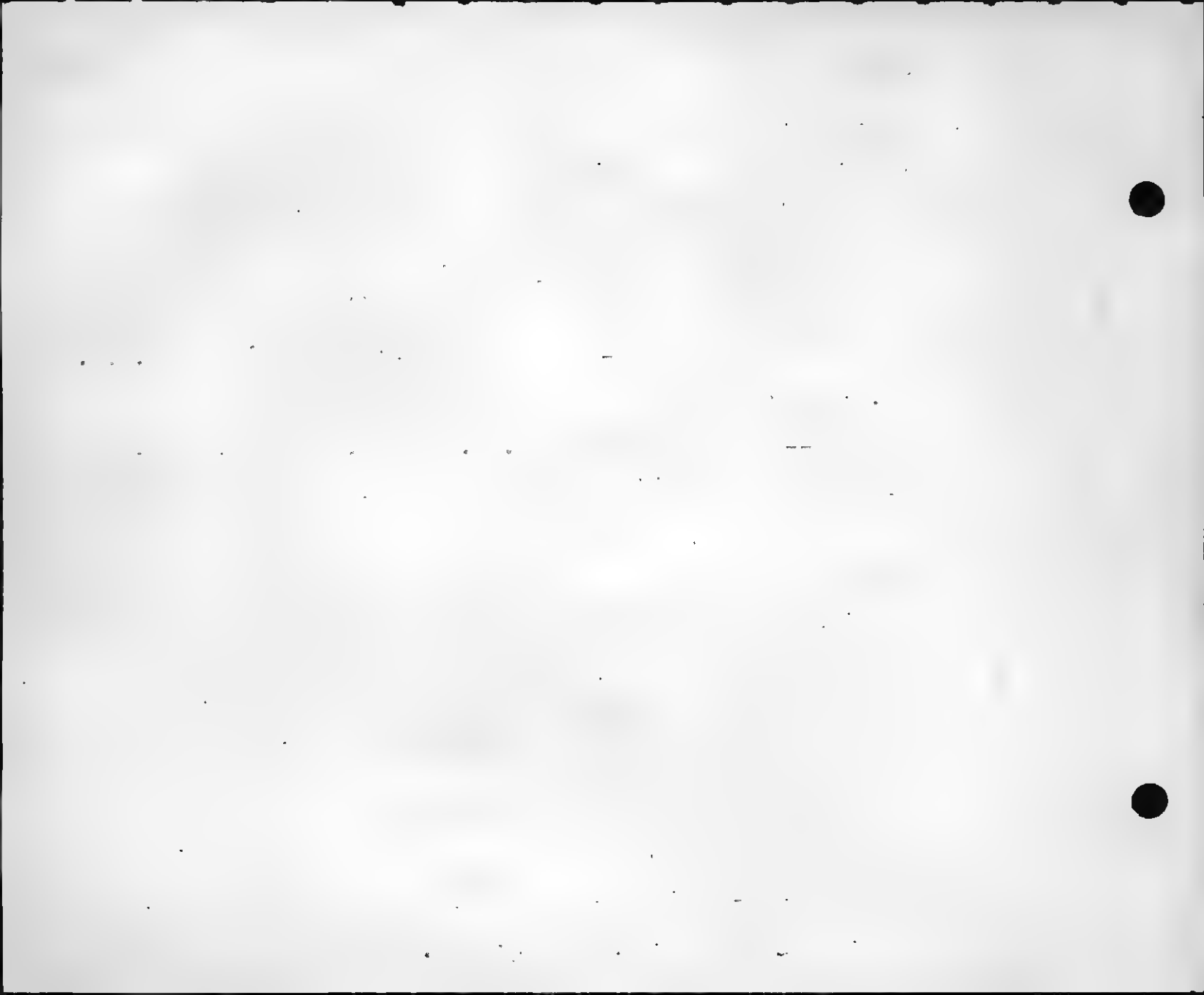


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
17172
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 12 weeks			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springhill Sanitarium				d. STREET ADDRESS 208 Sixth Street			
3. NAME OF DECEASED (Type or print) First MARTHA Middle E. Last TAYLOR				4. DATE OF DEATH Month December Day 21 Year 1965			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 9, 1874	
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months 21 Days 19 Hours 15 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (County & State, or foreign country) Accomack County, Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Asa J. Taylor				14. MOTHER'S MAIDEN NAME Rosa Ann Justice			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT C. K. Duncan, Pocomoke City, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis 1538 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma colon. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 27, 1965 to 12-21, 1965 , that (I) (we) last saw the deceased alive on 12-14, 1965 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE Charles Judge				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Chas. H. Insley				22d. ADDRESS Salisbury, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-23-1965		23c. NAME OF CEMETERY First Baptist		23d. LOCATION (City, town or county) (State) Pocomoke City, Maryland	
24. FUNERAL DIRECTOR Robert H. Walbran				25a. REC'D BY REGISTRAR DEC 27 1965			
25b. REGISTRAR'S SIGNATURE Charles Judge							



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
17173
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u> d. STREET ADDRESS <u>234</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Violet</u> Middle <u>W.</u> Last <u>Taylor</u>		4. DATE OF DEATH Month <u>December</u> Day <u>19</u> Year <u>1965</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 26, 1904</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SECRETARY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM HOUSE AID</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>EASTON MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WINFIELD S. WALLACE</u>		14. MOTHER'S MAIDEN NAME <u>EVERLYN BAKER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>SCOTT WALLACE</u>		Address <u>Ocean City MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastases to Spine and Intestinal Tract</u> DUE TO (b) <u>Carcinoma of Uterus</u> DUE TO (c) <u>17173</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>Dec 4, 1965</u> to <u>Dec 19, 1965</u> , that (I) (<u>was</u>) last saw the deceased alive on <u>Dec 18, 1965</u> , and that death occurred at <u>5:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Thomas C. Hill, Jr.</u>		22b. DATE SIGNED <u>12/19/65</u>	
22c. PHYSICIAN'S NAME (Type) <u>Pine Bluff Road, Salisbury, Md.</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12/21/65</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>PRINCESS ANNE'S</u>		23d. LOCATION (City, town or county) (State) <u>MD</u>	
24. FUNERAL DIRECTOR <u>Anne A. Burbage</u>		25a. REC'D BY REGISTRAR <u>DEC 27 1965</u>	
ADDRESS <u>Bulfin Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



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15M 4-64

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>													
1. PLACE OF DEATH a. COUNTY <i>Worcester</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>SA, RURY</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>HEALTHSALA General Hospital</i>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Worcester</i> ✓ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Stockton, md 123 x 2</i> d. STREET ADDRESS <i>Box 125</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <i>Russell Edward Townsend</i>						4. DATE OF DEATH Month Day Year <i>December 6 1965</i>							
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Caucasian</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Dec. 12, 1902</i>		9. AGE (In years last birthday) <i>62 yrs.</i>		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Factory</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>					
13. FATHER'S NAME <i>William Townsend</i>						14. MOTHER'S MAIDEN NAME <i>Nora Rowley</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>22-2-074019</i>		17. INFORMANT Address <i>Elaine Hudson Siddletree, md.</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> 571X DUE TO <i>Nephrotic Syndrome</i> (b) DUE TO <i>Hypertension</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)												INTERVAL BETWEEN ONSET AND DEATH <i>6 weeks</i> <i>4 years</i> <i>4 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <i>Dec 10, 1965</i> to <i>Dec 6, 1965</i>, that (I) (we) last saw the deceased alive on <i>Dec 6 1965</i>, and that death occurred at <i>9P</i> M, from the causes and on the date stated above.													
22a. SIGNATURE <i>David F. J. M.D.</i>						M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>12-9-65</i>					
22c. PHYSICIAN'S NAME (Type) <i>DAVID F. J. M.D.</i>						22d. ADDRESS <i>Stockton, MD</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12-12-65</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Home Beneficial</i>		23d. LOCATION (City, town or county) (State) <i>Stockton, md.</i>							
24. FUNERAL DIRECTOR <i>Edgar Wharton - new church, Va.</i>						25a. REC'D BY REGISTRAR <i>DEC 15 1965</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					



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17175

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b <u>17 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 SALISBURY</u> d. STREET ADDRESS <u>510 PRICILLA ST</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LILLIE J. TYRE</u>				4. DATE OF DEATH Month Day Year <u>DEC 29 19 65</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 15, 1886</u>	
9. AGE (In years last birthday) <u>79 yrs.</u>		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SELF EMP</u>		11. BIRTHPLACE (County & State, or foreign country) <u>NEWARK MD</u>	
13. FATHER'S NAME <u>ISAAC H. JONES</u>				14. MOTHER'S MAIDEN NAME <u>ELIZA ESHAM.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>219-14-3211 A</u>		17. INFORMANT Address <u>MRS. BROWNIE POWELL, SALISBURY MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>use.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1963</u> , 19 <u> </u> to <u>death</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>Dec 22 19 63</u> , and that death occurred at <u>9P</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>L. J. Lawry, M.D.</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Salisbury Md.</u>						22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12/31/65</u>		23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		23d. LOCATION (City, town or county) (State) <u>BERLIN MD</u>	
24. FUNERAL DIRECTOR <u>Anna A. Burbage</u> ADDRESS <u>Berlin Md.</u>				25a. REC'D BY REGISTRAR <u>JAN 3 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u>		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) e. STATE <u>Md</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tyaskin</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Kenneth</u> Middle <u>E</u> Last <u>Waters</u>		4. DATE OF DEATH Month <u>12</u> Day <u>22</u> Year <u>1965</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-28-65</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <u>1</u> Months <u>11</u> Days <u>24</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Kenneth E. Waters</u>		14. MOTHER'S MAIDEN NAME <u>Bertha Dickerson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Kenneth Waters, Tyaskin, MD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Interstitial pneumonia</u> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>days</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer, M.D.</u>		22. DATE SIGNED <u>12-23-65</u>	
EXAMINER'S NAME (Type) <u>109 Camden Ave. Salisbury, Md.</u>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>12/23/65</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Tyaskin Cem.</u>	23d. LOCATION (City, town or county) (State) <u>Tyaskin, Md.</u>
24. FUNERAL DIRECTOR <u>W. J. Bivins, Bivins, Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 28 1965</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
SM 1/63

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH </div>														
1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Salisbury c. LENGTH OF STAY IN MD d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Naylor Road						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Georgia b. COUNTY Appling c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baxley Rural d. STREET ADDRESS Route 3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>								
3. NAME OF DECEASED (Type or print) Henry			4. DATE OF DEATH Month Dec. Day 18 Year 1965			5. SEX Male			6. COLOR OR RACE White			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH Nov. 13, 1930			9. AGE (In years last birthday) 35 yrs. <div> IF UNDER 1 YEAR: Months 0 Days 0 IF UNDER 24 HRS.: Hours 0 Min. 0 </div>			10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinest			10b. KIND OF BUSINESS OR INDUSTRY Machinery			11. BIRTHPLACE (State or foreign country) Georgia		
12. CITIZEN OF WHAT COUNTRY? USA						13. FATHER'S NAME Unknown								
14. MOTHER'S MAIDEN NAME Sarah Wells						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) <div> 16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Aline M. Wells Address Route 3 Baxley, Georgia </div>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <div> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of Skull 8104 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) </div> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto struck by train - (Driver of Auto)								
20c. TIME OF INJURY Month, Day, Year 10:25 a.m. 12/23/65			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) Naylor Rd			20f. (City or town) Salisbury (County) Wicomico (State) MD					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE Earl L. Royer						CHIEF MEDICAL EXAMINER <input type="checkbox"/>								
EXAMINER'S NAME (Type) Earl L. Royer M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>								
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED 12-19-65								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 12/23/1965			22c. NAME OF CEMETERY OR CREMATORY Satilla Cemetery			22d. LOCATION (City, town, or county) Jeff Davis County, Ga. (State)					
23. FUNERAL DIRECTOR Thomas Wallace Salisbury, Maryland ADDRESS						24a. REC'D BY REGISTRAR DEC 21 1965			24b. REGISTRAR'S SIGNATURE J. Charles Judge					

MEDICAL CERTIFICATION

1

Handwritten text, possibly a signature or date.

Handwritten text, possibly a list or set of instructions.

Handwritten text, possibly a signature or date.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>17178</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>RT # 2</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Lola Mae Whaley</u>		First <u>Lola</u> Middle <u>Mae</u> Last <u>Whaley</u>		4. DATE OF DEATH <u>December 2 1965</u>		Month <u>December</u> Day <u>2</u> Year <u>1965</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-31-1905</u>		9. AGE (in years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>DEL.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>			
13. FATHER'S NAME <u>JAMES WOOTTEN</u>						14. MOTHER'S MAIDEN NAME <u>FLORENCE WILSON</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>222-07-2834</u>		17. INFORMANT <u>EARL WHALEY-SALISBURY</u>		Address <u>MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 321X DUE TO (b) <u>" Anteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH <u>One month</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 11, 1965</u> to <u>Dec. 2, 1965</u> , that (I) (we) last saw the deceased alive on <u>Dec. 2, 1965</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>[Signature]</u>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12-6-65</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. STEPHENS</u>		23d. LOCATION (City, town or county) (State) <u>DELMAR-DE</u>					
24. FUNERAL DIRECTOR, ADDRESS <u>[Signature]</u>						25a. REC'D BY REGISTRAR <u>DEC 6 1965</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
17179					CERTIFICATE OF DEATH					20561	
1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 12 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pen. Gen. Hospital					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 610 Truitt Street					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle MILBOURNE Last WILLING					4. DATE OF DEATH Month DEC. Day 22nd Year 19 65		5. SEX Male			6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH August 28/1900		9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 3 Days 24 Hours Min. 		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Radio Repairman					10b. KIND OF BUSINESS OR INDUSTRY Radio		11. BIRTHPLACE (County & State, or foreign country) Nanticoke, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME George Willing					14. MOTHER'S MAIDEN NAME Leah Webster						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 217-30-8485		17. INFORMANT Mrs. Iressia N. Willing (Wife) Address 610 Truitt Street Salisbury, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary arteriosclerosis DUE TO (c) 								INTERVAL BETWEEN ONSET AND DEATH 20 min 6 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from App. 21, 1965 to Dec 22, 1965 , that (I) (we) last saw the deceased alive on Dec 20, 1965 , and that death occurred at 11:47 P.M. from the causes and on the date stated above.											
22a. SIGNATURE [Signature]					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Dec. 24/1965				
22c. PHYSICIAN'S NAME (Type) Dr. L.V. Sohler					22d. ADDRESS Delmar, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Dec. 27/1965		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery			23d. LOCATION (City, town or county) (State) Salisbury, Maryland			
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY ADDRESS SALISBURY, MARYLAND					25a. REC'D BY REGISTRAR DEC 28 1965		25b. REGISTRAR'S SIGNATURE [Signature]				

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

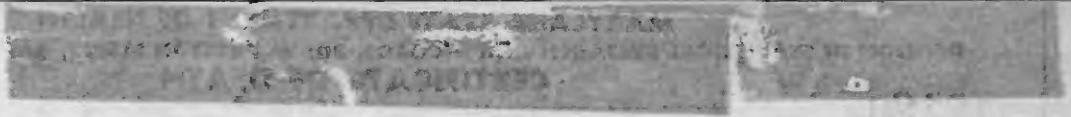
20562

1. PLACE OF DEATH e. COUNTY <u>Wicomico</u> f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> g. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eden (Rural)</u> d. STREET ADDRESS <u>R.D.# 1</u>					
3. NAME OF DECEASED (Type or print) <u>Norman Linwood Wilson</u>		4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>27</u> Year <u>1965</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 13/1905</u>				
9. AGE (In years last birthday) <u>60</u> yrs. <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months <u>4</u> Days <u>14</u></td> <td>Hours <u></u> Min. <u></u></td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months <u>4</u> Days <u>14</u>	Hours <u></u> Min. <u></u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Employee - Frozen Food Co.</u>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.						
Months <u>4</u> Days <u>14</u>	Hours <u></u> Min. <u></u>						
11. BIRTHPLACE (County & State, or foreign country) <u>Wor. County, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>					
13. FATHER'S NAME <u>Josiah Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Lena T. Shockley</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-12-0266</u>					
17. INFORMANT <u>Mrs. Eva E. Wilson (Wife) R.D.#1 Eden, Maryland</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> (b) <u>Coronary atherosclerosis</u> (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>SEC.</u> <u>YEARS</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> <u>12-27</u> <u>1965</u> to <u>12-27</u> <u>1965</u> that (I) (we) last saw the deceased alive on <u>19</u> <u>12-27</u> <u>1965</u> and that death occurred at <u>12:30 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Hubert R. White, Jr.</u>		22b. DATE SIGNED <u>Dec. 27/1965</u>					
22c. PHYSICIAN'S NAME (Type) <u>Dr. Hubert R. White, Jr.</u>		22d. ADDRESS <u>Fruitland, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Dec. 30/1965</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Zion Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Near Fruitland, Maryland</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>		25a. REC'D BY REGISTRAR <u>DEC 28 1965</u>					
ADDRESS <u>SALISBURY, MARYLAND</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

1950



[Faint, mostly illegible text covering the main body of the page, possibly a letter or report.]